

Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities: Certification

Border Status Providers

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

Exceptions to this policy include:

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

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

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

For more information about out-of-state providers, refer to [DHS 105.48](#), Wis. Admin. Code.

CLIA Certification or Waiver

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

CLIA Enrollment

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

CLIA Regulations

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

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

Scope of CLIA

CLIA governs all laboratory operations including the following:

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

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

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

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

CLIA Certification Types

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

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

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

Applying for CLIA Certification

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

Division of Quality Assurance

Clinical Laboratory Section
1 W Wilson St
PO Box 2969
Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify the Clinical Laboratory Section in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify the Clinical Laboratory Section of changes in certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Providers may reach the Clinical Laboratory Section at (608) 261-0653.

Categories of Certification

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

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

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

Billing/Rendering Provider

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

Rendering Provider

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

Group Billing

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

Group Billing That Requires a Rendering Provider

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

Group Billing That Does Not Require a Rendering Provider

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

provider on claims.

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

Certification Application

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

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

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

Providers may submit [certification applications](#) by mail or through the ForwardHealth Portal.

General Certification Information

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

Certification Requirements

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

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

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

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

Terms of Reimbursement

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

Provider Application

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

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

Provider Agreement and Acknowledgement of Terms of Participation

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

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

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

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

Completing Certification Applications

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

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

Portal Submission

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

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an ATN to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their records.

Paper Submission

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

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

ForwardHealth

Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Written requests for certification materials must include the following:

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

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

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

Declaration of Supervision

PTAs, COTAs and SLP provider assistants are required to complete the [Declaration of Supervision for Nonbilling Providers form](#) for changes in physical address or supervising therapist.

Durable Medical Equipment and Disposable Medical Supplies

Medicaid-certified PT, OT, and SLP providers do not need separate certification to dispense certain DME and DMS.

Effective Date of Medicaid Certification

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

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
 - The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
 - ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
 - ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or

unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).

4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

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

ForwardHealth
 Provider Maintenance
 6406 Bridge Rd
 Madison WI 53784-0006

Request for Change of Effective Date

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

Medicare Enrollment

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

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

Materials for New Providers

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

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

Multiple Services

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

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

NPI.

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

Noncertified In-State Providers

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

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

Noncertified in-state providers may call [Provider Services](#) with questions.

Notice of Certification Decision

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

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

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

Out-of-State Providers

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

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

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

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

Claims from noncertified out-of-state providers must be submitted with an [Out-of-State Provider Data Sheet](#). The Out-of-State

Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

Out-of-state providers may contact [Provider Services](#) with questions.

Overview of Certification and Reimbursement

	Certification Requirements	Reimbursement	Provider Numbers
Physical Therapists	Physical therapists may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. PT 1, Wis. Admin. Code.	Wisconsin Medicaid directly reimburses physical therapists for covered PT services when all program requirements are met.	Wisconsin Medicaid assigns physical therapists a billing performing provider number. The billing performing provider number can be used as a billing number and a performing provider number. It allows physical therapists to do the following: <ul style="list-style-type: none"> • Request PA and submit claims. • Request PA and submit claims for the services of PTAs, PT students, and PT aides who are supervised by the physical therapist.
Physical Therapist Assistants	Physical therapist assistants may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. PT 5, Wis. Admin. Code.	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 nonbilling performing provider number. The nonbilling performing provider number can be used as a performing provider number but not as a billing number. The nonbilling provider number does not allow PTAs to request PA, submit claims, or receive reimbursement.
Physical Therapy Aides*	Wisconsin Medicaid does not certify PT aides. A PT aide is an individual who provides delegated PT services and is trained in a manner appropriate to his or her job duties.	Wisconsin Medicaid does not directly reimburse PT aides. When all program requirements are met, covered PT services delegated to and provided by PT aides may be reimbursed under either of the following: <ul style="list-style-type: none"> • The supervising therapist's, rehabilitation agency's, or hospital's (for outpatient services) billing number. • The supervising therapist's performing provider number <i>and</i> the therapy group's, therapy clinic's, hospital's (for off-site services), or nursing home's billing number. 	Wisconsin Medicaid does not assign a performing provider number or a billing number to PT aides.
	Occupational therapists may	Wisconsin Medicaid directly reimburses	Wisconsin Medicaid assigns

Occupational Therapists	become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. OT 2, Wis. Admin. Code.	occupational therapists for covered OT services when all program requirements are met.	<p>occupational therapists a billing performing provider number.</p> <p>The billing performing provider number can be used as a billing number and a performing provider number. It allows occupational therapists to do the following:</p> <ul style="list-style-type: none"> • Request PA and submit claims. • Request PA and submit claims for the services of COTAs and OT students who are supervised by the physical therapist.
Certified Occupational Therapy Assistants	Occupational therapy assistants may become Medicaid certified if they are licensed under s. 448, Wis. Stats., and Ch. OT 2, Wis. Admin. Code.	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 group's, rehabilitation agency's, hospital's, or nursing home's billing number.	<p>Wisconsin Medicaid assigns COTAs a nonbilling performing provider number.</p> <p>The nonbilling performing provider number can be used as a performing provider number but not as a billing number. The nonbilling provider number does not allow COTAs to request PA, submit claims, or receive reimbursement.</p>
Speech-Language Pathologists	<p>Speech-language pathologists may become Medicaid certified if they are licensed under s. 459, Wis. Stats., and Ch. HAS, Wis. Admin. Code. They may also become Medicaid certified if any of the following are true:</p> <ul style="list-style-type: none"> • They are certified by the ASHA. • 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 services when all program requirements are met.	<p>Wisconsin Medicaid assigns speech-language pathologists a billing performing provider number.</p> <p>The billing performing provider number can be used as a billing number and a performing provider number. It allows speech-language pathologists to do the following:</p> <ul style="list-style-type: none"> • 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 Medicaid certified as SLP nonbilling performing providers. These individuals are referred to as SLP provider assistants.	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 nonbilling performing provider number. The nonbilling performing provider number can be used as a performing provider number but not as a billing number. The nonbilling provider number does not allow SLP provider assistants to request PA, submit claims, or receive reimbursement.
PT, OT, and SLP Students	Wisconsin Medicaid does not certify PT, OT, and SLP students. A PT, OT, or SLP student is an individual who is providing services during a practicum.	Wisconsin Medicaid does not directly 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: <ul style="list-style-type: none"> • The supervising therapist's, rehabilitation agency's, or hospital's (for outpatient services) billing number. • The supervising therapist's performing provider number <i>and</i> the therapy group's, therapy clinic's, speech and hearing clinic's, hospital's (for off-site services), or nursing home's billing number. 	Wisconsin Medicaid does not assign a performing provider number or a billing number to PT, OT, or SLP students.
Therapy Groups, Therapy Clinics, or Speech and Hearing Clinics	<p>Therapy groups that provide two or more types of therapy (e.g., PT and OT or PT, OT, and SLP) may become Medicaid certified as a therapy group.</p> <p>Therapy clinics that provide one type of therapy (e.g., PT or OT) may become Medicaid certified as a therapy clinic.</p> <p>Speech and hearing clinics may become Medicaid certified if they are accredited by the ASHA.</p> <p>Wisconsin Medicaid requires providers employed by, or under contract to, groups and clinics to be individually certified by Wisconsin Medicaid.</p>	Wisconsin Medicaid directly reimburses groups or clinics for covered PT, OT, and SLP services when all program requirements are met.	<p>Wisconsin Medicaid assigns groups and clinics a group billing number that requires individual performing provider numbers. Wisconsin Medicaid assigns an individual performing provider number to each Medicaid-certified provider within the group or clinic.</p> <p>The group billing number used with an individual performing provider number allows groups or clinics to do the following:</p> <ul style="list-style-type: none"> • Request PA and submit claims. • Receive one reimbursement and one R/S Report and 835 transaction for services performed by individual providers within the group or clinic.

<p>Rehabilitation Agencies</p>	<p>Rehabilitation agencies must be certified by Medicare to obtain Medicaid certification.</p> <p>Wisconsin Medicaid requires providers employed by, or under contract to, rehabilitation agencies to meet all Medicaid certification requirements, but does not require them to be individually certified by Wisconsin Medicaid. The rehabilitation agency is required to maintain records showing that its individual providers meet Medicaid requirements.</p> <p>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.</p> <p>For information about Medicare certification, providers should contact the Division of Disability and Elder Services at the following address:</p> <p>Bureau of Quality Assurance Division of Disability and Elder Services PO Box 2969 Madison WI 53701-2969</p>	<p>Wisconsin Medicaid directly reimburses rehabilitation agencies for covered PT, OT, and SLP services when all program requirements are met.</p>	<p>Wisconsin Medicaid assigns rehabilitation agencies a group billing number that does <i>not</i> require a separate performing provider number. Wisconsin Medicaid does not assign an individual performing provider number to each provider within the rehabilitation agency.</p> <p>The group billing number can be used as a billing number and a performing provider number. It allows rehabilitation agencies to do the following:</p> <ul style="list-style-type: none"> • 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.
<p>*Medicaid reimbursement is not available for services provided by OT or SLP aides.</p>			

Provider Addresses

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

- *Practice location address and related information (formally known as physical address).* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and telephone number for member's use. With limited exceptions, the practice location and telephone number for member's use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should

indicate concise address information to aid in proper mail delivery.

- *PA address*. This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address)*. Two separate financial addresses are stored in ForwardHealth interChange. The checks address is where Wisconsin Medicaid will mail paper checks. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

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

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

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

Provider Type and Specialty Changes

Providers who want to add a certification type or make a change to their certification type should call [Provider Services](#)

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

Reinstating Certification

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

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

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

Requirements

Physical therapists, PTAs, occupational therapists, COTAs, and speech-language pathologists offering services addressed in this handbook are required to be licensed through the Wisconsin [DR&L](#). Temporary licensure through the DR&L is sufficient but is subject to the terms of the DR&L. Program requirements may not be construed to supersede the provisions for registration or licensure under [s. 448](#), or [459.24](#), Wis. Stats.

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. [DHS 105.48](#), Wis. Admin. Code, contains more information about border status.

Wisconsin Medicaid requires providers offering *outpatient* hospital PT, OT, and SLP services who are employed by, or under contract to, hospitals to meet all Medicaid certification requirements but does not require them to be individually certified by 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 certified by Wisconsin Medicaid.

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

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, COTAs, SLP provider assistants, PT students, OT 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 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.	Physical therapist assistants must be under the direct, immediate, on-premises supervision of a Medicaid-certified 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-certified physical therapist.
COTAs	Certain OT services, such as evaluations, may not be reimbursed by Wisconsin Medicaid when provided by COTAs.	<p>For some services (i.e., activities of daily living skills), COTAs are required to be under the general supervision of a Medicaid-certified occupational therapist who is responsible for member care. The following circumstances must apply:</p> <ul style="list-style-type: none"> • The COTA is providing services that are for the purpose of providing activities of daily living skills. • The supervising therapist visits the recipient on a bi-weekly 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. <p>For all other services, COTAs must be under the direct, immediate, on-premises supervision of a Medicaid-certified occupational therapist who is responsible for member care. However, if a supervision waiver is obtained, COTAs may provide these services under general supervision.</p>
	Evaluations (92506, 92597, 92607, 92608, and	Speech and language pathology provider assistants must be under

SLP Provider Assistants	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 provided by SLP provider assistants.	the direct, immediate, on-premises supervision of an ASHA-certified and Medicaid-certified speech-language pathologist who is responsible for member care.
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.	Physical therapy and OT students must be under the direct, immediate, on-premises supervision of a Medicaid-certified physical therapist or occupational therapist who is responsible for member care. Speech and language pathology students must be under the direct, immediate, on-premises supervision of an ASHA-certified and Medicaid-certified speech-language pathologist who is responsible for member care.
PT Aides	<p>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:</p> <ul style="list-style-type: none"> 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. <p>Clinical services that exceed a PT aide's competence, education, training, and experience are not reimbursable by Wisconsin Medicaid.</p>	<p>Physical therapy aides must be under the direct, immediate, one-to-one supervision of a Medicaid-certified physical therapist who is responsible for member care. The therapist-to-aide ratio must be 1:1, except as noted.</p> <p>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.</p> <p>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.</p>

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's 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 DR&L. Each billing provider should complete the [Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements form](#) only once. Providers should retain copies of these forms for certification 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.

Tracking Certification Materials

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

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

Tracking Through the Portal

Providers are able to track the status of a certification application through the [Portal](#) by entering their ATN. Providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

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

Communication

Coordination with County Birth to 3 Programs

Per [DHS 90.07\(3\)\(b\)](#), Wis. Admin. Code, PT, OT, and SLP providers are required to refer children who may be eligible for B-3 services to the appropriate county B-3 program within two working days of identification.

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

For general information about the B-3 program, refer to the following:

- [Administration and Regulations](#).
- [Eligibility Criteria](#).
- [Individualized Family Services Plan](#).
- [Provision of Services in Natural Environment](#).
- [Requirements for Providers](#).

Coordination with School-Based Services Providers

A member who receives SBS may also receive PT, OT, and SLP services that are not included in the ForwardHealth SBS benefit.

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 or components of the IEP team evaluation.

Directory of Used Medical Equipment

A [directory](#) of established community agencies and organizations throughout Wisconsin that accept used medical equipment is available for members and their families. When a member has equipment that is no longer needed, he or she may donate the used equipment.

Guide to Obtaining Augmentative Communication Devices and Accessories

A booklet titled "[A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid](#)" is available for members and their families. The booklet covers a variety of topics including devices that are covered by ForwardHealth and the PA process.

Requirements

BadgerCare Plus PT, OT, and SLP 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 B-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 providers.
- Therapists.
- Tribal health agencies.

Providers are required to document their communication with other providers in the member's medical record.

Therapy Services for Children Brochure

A brochure titled "[Medicaid Therapy Services for Children](#)" is available for families with children who are eligible for BadgerCare Plus PT, OT, and SLP services. The question-and-answer format of the brochure covers a variety of topics including how to access PT, OT, and SLP services for children and the PA process. This brochure does not address services provided through the SBS benefit.

Documentation

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than \$600.00, per 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 share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Availability of Records to Authorized Personnel

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

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

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

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

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

Confidentiality

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

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

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

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

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

Daily Entries

PT, OT, and SLP providers are required to write a note in the member's medical record for every DOS. 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.

Evaluations

PT, OT, and SLP 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 recipient'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 recipient.
- 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.
- Previous level of function and change in medical status since previous prior authorization requests if performing a re-evaluation.
- Reason for the referral.
- Test charts or forms used in the evaluation.
- Underlying conditions or impairments to be treated.

Financial Records

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

Medical Records

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

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services,

maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

Per [s. 146.83](#), Wis. Stats., providers may not 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. Members who are enrolled on the date of the records request may obtain one free copy of each document in their record. This applies regardless of the member's enrollment status on the dates of service contained within the health care records.

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

For information regarding fees that may be charged to members for health care records, such as paper copies, microfiche, and X-rays beyond the first set of copies, refer to [s. 146.83\(1f\)](#), Wis. Stats.

Fee Refunds

If a provider has collected a fee for the first set of copies of health care records provided to an enrolled member, and the member requests a refund, the provider is required to refund the fee to the member.

Overview

As stated in [DHS 106.02\(9\)](#), Wis. Admin. Code, 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, OT, and SLP 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.
- 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.

Plan of Care

PT, OT, and SLP providers are required to establish a written POC 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. Such documentation includes 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.

Preparation and Maintenance of Records

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

Prescription

To receive reimbursement for PT, OT, and SLP services, Wisconsin BadgerCare Plus 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 is required.

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, who are required to retain records for a minimum of six years from the date of payment.

According to [DHS 106.02\(9\)\(d\)](#), Wis. Admin. Code, 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.

Reviews and Audits

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

Records Requests

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

[Provider Services](#) when releasing billing information or medical claim records relating to charges for covered services except the following:

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

Request from a Member or Authorized Person

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

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

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

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

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

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

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

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

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

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

Request for a Statement from a Dual Eligible

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

For More Information

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

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

Release of Billing Information to Government Agencies

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

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

Ongoing Responsibilities

Accommodating Members with Disabilities

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

Change in Ownership

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

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

The following provider types require Medicare enrollment and/or [DQA certification](#) for Wisconsin Medicaid certification change in ownerships:

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

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

Providers with questions about change in ownership should call [Provider Services](#).

Repayment Following Change in Ownership

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

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

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

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

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

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

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

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

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

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

AA/CRC Office
1 W Wilson St Rm 561

PO Box 7850
Madison WI 53707-7850

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

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

Americans with Disabilities Act of 1990

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

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of

communication, unless doing so would fundamentally alter the operation or result in undue burdens.

3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

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

Contracted Staff

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

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

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

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

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

Examples of Ongoing Responsibilities

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

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

- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Keeping Information Current

Types of Changes

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

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

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

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

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

Address Changes

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

Submitting Changes in Address or Status

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

ForwardHealth Portal Submission

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

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

Paper Submission

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

Change Notification Letter

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

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

Notify Division of Quality Assurance of Changes

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

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

Legal Framework

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

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

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

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

The following laws and regulations provide the legal framework for PT, OT, and SLP services:

- [Section 15](#), Wis. Stats., gives general powers to examining boards that license PT, OT, and SLP providers.
- [Section 227](#), Wis. Stats., gives an agency the authority to promulgate rules.
- [Section 448](#), Wis. Stats., outlines the qualifications for licensure or certification of PT or OT providers.
- [Section 459](#), Wis. Stats., outlines the qualifications for licensure of SLP providers.
- [Section 448](#), Wis. Stats., and Ch. PT, Wis. Admin. Code, define the scope of practice for PT providers.

- [Section 448](#), Wis. Stats., and Ch. OT, Wis. Admin. Code, define the scope of practice for OT providers.
- [Section 459](#), Wis. Stats., and Ch. HAS, Wis. Admin. Code, define the scope of practice for SLP providers.

Provider Numbers

National Provider Identifier

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

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

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

There are two kinds of NPIs:

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

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

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

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

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

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

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

Taxonomy Codes

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

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

Omission of a taxonomy code when it is required as additional data to identify the provider or indicating a taxonomy code that is not

designated by ForwardHealth will cause claims and other transactions to be denied or delayed in processing.

Refer to the [ForwardHealth-designated taxonomy codes](#) for the appropriate taxonomy code for your certification.

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

ZIP Code

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

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

Providers may verify the ZIP+4 code for their address on the [U.S. Postal Service Web site](#).

Provider Rights

A Comprehensive Overview of Provider Rights

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

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

Ending Participation

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

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

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

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

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

ForwardHealth
 Provider Maintenance
 6406 Bridge Rd
 Madison WI 53784-0006

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

Hearing Requests

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

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

Refer to [DHS 106](#), Wis. Admin. Code, for detailed instructions on how to file an appeal.

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

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

Limiting the Number of Members

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

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

Requesting Discretionary Waivers and Variances

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

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

Requirements

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

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

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

Application

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

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

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

Division of Health Care Access and Accountability

Waivers and Variances
PO Box 309
Madison WI 53701-0309

Recertification

An Overview

Each year approximately one-third of all Medicaid-certified providers undergo recertification. During provider recertification, providers update their information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the provider recertification process to continue their participation with Wisconsin Medicaid. For most providers, recertification will be conducted online at the ForwardHealth Portal. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Checking the Status of a Recertification Application

Providers may check the status of their recertification on the [ForwardHealth Portal](#) by entering the ATN from the Provider Recertification Notice and pressing "Search."

Providers will receive one of the following status responses:

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

Notification Letters

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

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

The letters are sent to the mailing address on file with Wisconsin Medicaid. Providers should read these letters carefully and keep them

for reference. The letters contain information necessary to log in to the secure Recertification area of the Portal to complete recertification. If a provider needs to replace one of the letters, the recertification process will be delayed.

Paper Recertification Applications

Providers who do not have Internet access or who are not able to complete recertification via the ForwardHealth Portal should contact [Provider Services](#) to request a paper recertification application. Providers who request a paper application are required to complete the recertification process on paper and not online via the Portal to avoid duplicate recertification submissions.

Recertification Completed by an Authorized Representative

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

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

Recertification on the ForwardHealth Portal

Logging in to the Secure Recertification Area of the Portal

Once a provider has received the Provider Recertification Notice and PIN letter, the provider may log in to the Recertification area of the ForwardHealth Portal to begin the recertification process.

The Recertification area of the Portal is not part of a Provider Portal account. Providers do not need a Provider Portal account to participate in recertification via the Portal. Providers are not able to access the Recertification area of the Portal by logging in to a Provider Portal account; providers must use the ATN from the Provider Recertification Notice and PIN from the PIN letter to log in to the Recertification area of the Portal.

The Portal will guide providers through the recertification process. On each screen, providers are required to complete or verify information.

Completing Recertification

Providers are required to complete all of the recertification screens in a single session. The Portal will not save a provider's partial progress through the recertification screens. If a provider does not complete all of the recertification screens in a single session, the provider will be required to start over when logging in to the Recertification area of the Portal again.

It is important to read the final screen carefully and follow all instructions before exiting the recertification process. After exiting the recertification process, providers will not be able to retrieve the provider recertification documents for their records.

The final screen of the recertification process gives providers the option to print and save a PDF version of the recertification information submitted to ForwardHealth. Providers whose recertification is approved immediately will also be able to print a copy of the approval letter and the Provider Agreement signed by the DHS.

In other cases, the final screen will give providers additional instructions to complete recertification, such as the following:

- The recertification application requires review. Providers are mailed the approval letter and other materials when the application is approved.
- Some providers may be required to send additional paper documentation to ForwardHealth.

Sanctions

Intermediate Sanctions

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

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

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

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

Involuntary Termination

The DHS may suspend or terminate the Medicaid certification of any provider according to [DHS 106.06](#), Wis. Admin. Code.

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

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

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

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

Sanctions for Collecting Payment from Members

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

There may be narrow exceptions on when providers may [collect payment from members](#).

Withholding Payments

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

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting

attorney against the provider or one of the provider's agents or employees.

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

Claims

2

Archive Date:09/01/2010

Claims:Adjustment Requests

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 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.

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.

Electronic

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

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may [download it](#) or contact the [EDI Helpdesk](#).

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 Helpdesk](#) for assistance with electronic adjustment requests.

Paper

Paper adjustment requests must be submitted using the [Adjustment/Reconsideration Request](#) form.

Portal Claim Adjustments

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

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.

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 (e.g., medical, dental).

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to ForwardHealth.

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Definition

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 card or an EE card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's EVS indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related EOB code, providers should contact [Provider Services](#) for assistance.

Overpayments

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.

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 certified on the DOS.
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under [DHS 106.08](#), Wis. Admin. Code.
- 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

ForwardHealth will deduct the overpayment when the [electronic adjustment request](#) is processed. Providers should use the [companion document](#) for the appropriate 837 transaction when submitting adjustment requests.

Paper Adjustment Requests

For [paper adjustment requests](#), providers are required to do the following:

- Submit an [Adjustment/Reconsideration Request](#) 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, ForwardHealth will deduct the overpayment from future reimbursement amounts.

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA 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, the NPI (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

6406 Bridge Rd
Madison WI 53784-0004

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.

Requirements

As stated in [DHS 106.04\(5\)](#), Wis. Admin. Code, 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 (e.g., 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.

Voiding Claims

Providers may void claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a voided claim is a complete recoupment of the payment for the entire claim. Once a claim is voided, the claim can no longer be adjusted; however, the services indicated on the voided claim may be resubmitted on a new claim.

Responses

An Overview of the Remittance Advice

The RA 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 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 new [CSV](#) format.

National Provider Identifier on the Remittance Advice

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

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA appear at the end of the adjusted claims and paid claims sections in the TXT file. Pay-out amounts are in the Financial Transactions section in the CSV. ForwardHealth calculates the total by adding the amounts for all of the claims; 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 codes and will not display an exact dollar amount.

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned an ICN.

Interpreting Claim Numbers

The [ICN consists of 13 digits that identify valuable information](#) (e.g., the date the claim was received by ForwardHealth, how the claim was submitted) about the claim or adjustment request.

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](#) system or the 276/277 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.

Information is available for [DOS before September 1, 2010](#).

ClaimCheck Review

ForwardHealth monitors all professional claims for compliance with reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. Insurance companies, Medicare, and other state Medicaid programs use similar software.

EOB codes specific to the ClaimCheck review appear in the TXT RA file and in the electronic 835 transactions.

ClaimCheck review does not change Medicaid or BadgerCare Plus policy on covered services but monitors compliance with policy more closely and reimburses providers appropriately.

Areas Monitored by ClaimCheck

ForwardHealth uses ClaimCheck software to monitor the following situations:

- Unbundled procedures.
- Incidental/integral procedures.
- Mutually exclusive procedures.
- Medical visit billing errors.
- Preoperative and postoperative billing errors.
- Medically obsolete procedures.
- Assistant surgeon billing errors.

Effective for dates of process on and after September 1, 2010, ForwardHealth will begin to use ClaimCheck software to monitor claims for gender-related billing errors.

ClaimCheck 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 ClaimCheck will review the claim.

Unbundled 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. ClaimCheck considers the single, most appropriate procedure code for reimbursement when unbundling is detected.

If certain procedure codes are submitted, ClaimCheck rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with procedure codes 12035 (Layer of closure of wounds, 12.6 cm to 20.0 cm) and 12036 (Layer closure of wounds, 20.1 cm to 30.0 cm), ClaimCheck rebundles them to procedure code 12037 (Layer closure of wounds over 30.0 cm).

ClaimCheck will also total billed amounts for individual procedures. For example, if the provider bills three procedures at \$20, \$30, and \$25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that 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 cystourethroscopy (procedure code 52000) is considered integral to the performance of the prostate procedure and would be denied.

When a procedure is either incidental or integral to a major procedure, ClaimCheck 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.

For example, procedure code 58260 (Vaginal hysterectomy, for uterus 250 g or less) and procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) are mutually exclusive — either one or the other, but not both procedures, is performed.

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 services are reported separately when a substantial diagnostic or therapeutic procedure is performed. Under CMS guidelines, most E&M procedures are not allowed to be reported separately when a substantial diagnostic or therapeutic procedure is performed.

Medical visit edits monitor services included in CPT procedure ranges 92002-92019, 99024 (postoperative follow-up), 99026-99058 (special services), 99201-99456 (E&M codes) and HCPCS codes S0620, S0621 (routine ophthalmological examinations).

ClaimCheck monitors medical visits based on the type of E&M service (i.e., initial or new patient; or follow-up or established patient services) and the complexity (i.e., major or minor) of the accompanying procedure.

For example, if a provider submits procedures 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace [other than for decompression], single interspace; lumbar) and 99221 (Initial hospital care, per day), ClaimCheck denies procedure 99221 as a visit when submitted with procedure 22630 with the same DOS. Procedure code 22630 is a major procedure with a 90-day global surgical period.

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. ClaimCheck bases the preoperative and postoperative periods on designations in the CMS National Physician Fee Schedule.

For example, if a provider submits procedure code 99212 (Office or outpatient visit for the evaluation and management of an established patient) with a DOS of 11/02/08 and procedure 27750 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; without manipulation) with a DOS of 11/03/08, ClaimCheck will deny procedure code 99212 as a preoperative visit because it is submitted with a DOS one day prior to the DOS for procedure code 27750.

Medically Obsolete Procedures

Obsolete procedures are procedures that are no longer performed under prevailing medical standards. Claims for procedures designated as obsolete are denied.

Assistant Surgeon Billing Errors

ClaimCheck development and maintenance of assistant surgeon values includes two designations, *always* and *never*. ClaimCheck uses the ACS as its primary source for determining assistant surgeon designations. Effective September 1, 2010, ForwardHealth will be updating the list of procedure codes allowable with an assistant surgeon designation to be consistent with ClaimCheck.

For example, if a provider bills procedure code 10040 (Acne surgery [eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules]) with modifier -80 (assistant surgeon), ClaimCheck determines that the procedure does not require an assistant surgeon and denies the procedure code.

Gender-Related Billing Errors

Gender-related billing errors occur when a provider submits a gender-specific procedure for a patient of the opposite sex. Effective for dates of process on and after September 1, 2010, ForwardHealth will be adopting ClaimCheck's designation of gender for procedure codes.

For example, if a provider submits procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) for a male, ClaimCheck will deny the procedure based on the fact that procedure code 58150 is a female gender-specific procedure.

Payments Denied as a Result of the ClaimCheck Review

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 current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If a provider disagrees with ClaimCheck's determination, the provider may resubmit the claim with supporting documentation to Provider Service Written Correspondence. If the original claim is in an allowed status, the provider may submit an [Adjustment/Reconsideration Request](#), with supporting documentation and the words, "medical consultant review requested" written on the form, to Provider Services Written Correspondence.

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 copayment, 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 copayments or spenddowns) will be indicated on the RA; the detail line EOB codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive [835](#) transactions will be able to see all deducted amounts on paid and adjusted claims.

Electronic Remittance Information

Providers are required to access their secure [ForwardHealth provider Portal account](#) to obtain their RAs. Electronic RAs on the Portal are not be 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 format or from a CSV 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 new "View Remittance Advices" menu. RAs from the last 97 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 in order 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 new "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 2.2.1. 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 X. For maximum file capabilities when downloading the CSV file, the 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended. 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.

The [CSV User Guide](#) includes 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](#) 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 claim submitted by a pharmacy using the NCPDP 5.1 transaction 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

The DHCAA offers electronic billing software at no cost to the provider. The [PES](#) software allows providers to download the 835 transaction. To obtain PES software, providers may request the software through the ForwardHealth Portal. Providers may also obtain the software by contacting the [EDI Helpdesk](#).

Explanation of Benefit Codes in the Claim Header and in the Detail Lines

EOB 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 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 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 file.

CSV File

EOB codes are listed in the RA information from the CSV file; however, the printed message corresponding to the codes do not appear in the file. The [EOB Code Listing](#) matching standard EOB codes to explanation text are available on the Portal for reference.

Identifying the Claims Reported on the Remittance Advice

The RA reports the first 12 characters of the MRN and/or a PCN, 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.

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RA. 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 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 97 days are available in the TXT format.

Providers can also access RAs in a [CSV](#) 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.

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA includes 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.
- 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.

Prior Authorization Number on the Remittance Advice

The RA reports PA numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

In the TXT file, the Address page displays the provider name and "Pay to" address of the provider.

Banner Messages

The Banner Messages section of the RA 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 file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

[EOB Code Descriptions](#) are listed in the RA information in the TXT file.

EOBs are listed in the RA information from the CSV file; however, the printed message corresponding to the codes does not appear in the file. The EOB listing matches standard EOB codes to explanation text is available on the Portal for reference.

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 (i.e., 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 under "Accounts Receivable." The "Total Recoupment" field lists the cumulative amount recovered for the accounts receivable.

Every financial transaction that results in the creation of an accounts receivable is assigned an identification number called the "adjustment ICN." The adjustment ICN for an adjusted claim matches the original ICN assigned to the adjusted claim. 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 (i.e., 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, WCDP, or WWWP) 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 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.

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a [Claim Adjustments section](#) in the RA 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.

In a claim adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the adjusted claim appears directly below the original claim header information. Providers should check the Adjustment EOB code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

The claim adjustments section lists detail lines only for the adjusted claim with detail line EOBs. Details from the original claim will not be reported on the adjusted claims sections of the RA.

Note: For adjusted drug 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."

An amount appears for "additional payment" if ForwardHealth owes additional monies to the provider after the claim has been adjusted. This amount will be added to the provider's total reimbursable amount for the RA.

An amount appears for "overpayment to be withheld" if ForwardHealth determines, as the result of an adjustment to the original claim, that the provider owes ForwardHealth monies. 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.

Reading the Claims Denied Section of the Remittance Advice

Providers receive a [Claims Denied](#) section in the RA 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 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.

Reading the Claims Paid Section of the Remittance Advice

Providers receive a [Claims Paid](#) section in the RA 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 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.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs 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 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.

Remittance Advice Generated by Payer and by Provider Certification

RAs 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).
- WCDP.
- WWWP.

A separate Portal account is required for each financial payer.

Note: Each of the three 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 certification. Providers who have a single NPI that is used for multiple certifications should be aware

that an RA will be generated for each certification, 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 certified 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.

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 and ForwardHealth-issued 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.)
- 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
 6406 Bridge Rd
 Madison WI 53784-0005

Searching for and Viewing All Claims on the Portal

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

Sections of the Remittance Advice

The RA information in the TXT file includes the following sections:

- Address page.
- Banner messages.
- Paper check information, if applicable.
- Claims processing information.
- EOB code descriptions.
- Financial transactions.
- Service code descriptions.
- Summary.

The RA information in the CSV 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.
- Drug claims.
- Dental claims.
- Long term care claims.
- Financial transactions.
- Summary.

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 (e.g., 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, WCDP, or WWWP).
- 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 (e.g., "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.
- 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.

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.

Responsibilities

Accuracy of Claims

The provider is responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by the provider or by an outside billing service or clearinghouse.

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.

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.

Exceptions to the Submission Deadline

State and federal laws provide eight exceptions to the submission deadline. According to federal regulations and [DHS 106.03](#), Wis. Admin. Code, ForwardHealth may consider exceptions to the submission deadline only in the following circumstances:

- Change in a nursing home resident's [level of care](#) or [liability amount](#).
- Decision made by a court order, fair hearing, or the DHS.
- 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.
- 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](#).

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. 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).

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 using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-program patients. 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 copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, BadgerCare Plus automatically deducts the copayment amount.

For most services, BadgerCare Plus reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established.

Submission

1500 Health Insurance Claim Form Completion Instructions for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

The following sample 1500 Health Insurance Claim Forms for therapy services are available:

- [PT.](#)
- [OT.](#)
- [SLP.](#)

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Wisconsin Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal for more information about verifying enrollment.

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.

Submit completed paper claims to the following address:

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

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other
Enter "X" in the Medicaid Check box.

Element 1a — Insured's ID Number

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's EVS to obtain the correct member ID.

Element 2 — Patient's Name

Enter the member's last name, 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 3 — Patient's Birth Date, Sex

Enter the member's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name

Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the

member's last name, first name, and middle initial.

Element 5 — Patient's Address

Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, and the service requires other insurance billing, one of the following three OI explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. 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 or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: <ul style="list-style-type: none"> • 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.

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)**Element 10a-10c — Is Patient's Condition Related to: (not required)****Element 10d — Reserved for Local Use (not required)****Element 11 — Insured's Policy Group or FECA Number**

Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does *not* have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>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, spell of illness, or yearly allotment of available benefits is exhausted.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for 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. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for 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	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for 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 (e.g., member's diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for 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 (e.g., member's diagnosis).

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source

Enter the referring physician's name.

Element 17a (not required)

Element 17b — NPI

Enter the NPI of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab —\$Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter a valid ICD-9-CM diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

Family Planning Services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are only contraceptive management related.

Element 22 — Medicaid Resubmission (not required)**Element 23 — Prior Authorization Number (not required)****Element 24**

The six service lines in Element 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.

Element 24A — Date(s) of Service

Enter to and from DOS in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one POS enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the place of service (POS), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each item used or service performed.

Element 24C — EMG (not required)**Element 24D — Procedures, Services, or Supplies**

Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer

Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

Element 24F — \$ Charges

Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)**Element 24I — ID Qual**

If the rendering provider's NPI is different than the billing provider number in Element 33A, enter a qualifier of "ZZ," indicating

provider taxonomy, in the *shaded area* of the detail line.

Note: Rehabilitation agencies and outpatient hospital physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) providers do not indicate a rendering provider number.

Element 24J — Rendering Provider ID. #

If the rendering provider's NPI is different than the billing provider number in Element 33A, enter the rendering provider's 10-digit taxonomy code in the shaded area of this element and enter the rendering provider's NPI in the white area provided for the NPI.

Note: Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a rendering provider number.

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the Remittance Advice and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

If a dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9. If the commercial health insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)**Element 33 — Billing Provider Info & Ph #**

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code.

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

If an NPI was entered in Element 33a, enter qualifier "ZZ" followed by the 10-digit provider taxonomy code.

Do not include a space between the qualifier "ZZ" and the provider taxonomy code.

Attached Documentation

Providers should not submit additional documentation with a claim *unless* specifically requested.

Birth to 3 Services

Federal regulations allow a B-3 member's parents or guardians to refuse consent to bill their commercial health insurance [34 CFR Part 303](#) if it would result in a cost to the family, such as:

- Reaching the lifetime limit on a policy.
- An increase in premiums, copayments, or deductibles.

B-3 agencies may reimburse the commercial health insurance liability when both of the following occur:

- The member participates in the B-3 Program and is receiving B-3 services.
- The parents or guardians do not allow their BadgerCare Plus provider or BadgerCare Plus HMOs to bill their commercial health insurance first.

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 along with the claim status.

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view [EOB codes](#) and descriptions for any claim submitted to ForwardHealth on the 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.

Crossover Claims for Outpatient Hospital Services

When submitting crossover claims (i.e., automatic crossover claims and provider-submitted crossover claims) for outpatient hospital

PT, OT, and SLP services, providers should follow Medicare's procedures.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE 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.
- Admission source.
- Admission type.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

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

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

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

- Diagnosis codes.
- NDCs.
- Patient location 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 or of DMS who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS claims, are viewable via DDE.

Electronic Claims Submission

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

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

Electronic claims for PT, OT, and SLP services must be submitted using the 837P 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 document](#) for the 837P transaction when submitting these claims.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may [download it](#) or contact the [EDI Helpdesk](#).

Evaluations

Claims for evaluations and re-evaluations may be submitted only upon completion regardless of the number of days needed to complete the evaluation.

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.

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.

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA compliance before being processed. Compliant code sets include CPT and HCPCS 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 are required in all provider number fields on paper claims and 837 transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV providers, blood banks, and CCOs should enter valid provider numbers into fields that require a provider number.

Managed Care Organizations

Claims for services that are covered in a member's state-contracted MCO should be submitted to that MCO.

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 may be indicated on the claim. Claims found to be in conflict with this program requirement will be recouped.

Noncertified Providers

Claims from [noncertified in-state providers](#) must meet additional requirements.

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the [Compound Drug Claim](#) and the [Noncompound Drug Claim](#).

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

- [Correct alignment](#) for the 1500 Health Insurance Claim Form.
- [Incorrect alignment](#) for the 1500 Health Insurance Claim Form.
- [Correct alignment](#) for the UB-04 Claim Form.
- [Incorrect alignment](#) for the UB-04 Claim Form.

Clarity

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

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

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

will be unable to read it.

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Anchor Fields

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

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

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

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

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

Paper Claim Submission

Paper claims for PT, OT, and SLP services must be submitted using the 1500 Health Insurance Claim Form (dated 08/05). Paper claims for PT, OT, and SLP services submitted on any other claim form will be denied.

The following sample 1500 Health Insurance Claim Forms and instructions for PT, OT, and SLP services are available:

- [PT Services](#).
- [OT Services](#).
- [SLP Services](#).

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.

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA and the 835 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.

Provider Numbers for Groups, Clinics, and Nursing Homes

When the performing 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.

Provider Numbers for Hospitals

When the performing provider is employed by, or under contract to, a hospital and offering *outpatient* hospital PT, OT, and SLP services, the billing provider number of the hospital must be indicated on the claim. A performing provider number should not be indicated.

When the performing 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 performing provider number should not be indicated.

When the performing 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 performing provider is a PTA, COTA, or SLP provider assistant, the performing provider number of the assistant must be indicated.

Provider Numbers for Individual Providers

When the performing provider is an individual therapist, the billing provider number of the therapist must be indicated on the claim. A performing provider number should not be indicated.

When the performing provider is supervised by an individual therapist, the billing provider number of the supervising therapist must be indicated on the claim. If the performing provider is a PTA, COTA, or SLP provider assistant, the performing provider of the assistant must be indicated.

Provider Numbers for Rehabilitation Agencies

When the performing 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 performing provider number should not be indicated.

Referring Provider

Claims for PT, OT, and SLP services require the referring physician's name and UPIN.

Services Provided Beyond Daily Limits

When a PT, OT, or SLP 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 form](#) must be submitted with documentation verifying that the duration of the service was medically necessary.

Submitting Paper Attachments with Electronic Claims

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

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

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

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

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

Unlisted Procedure Codes

Claims for services identified by unlisted procedure codes must be submitted on paper because a national standard for electronic claim attachments has not been established at this time. To receive reimbursement for a service identified by an unlisted procedure code, a description of the service must be indicated in Element 19 of the 1500 Health Insurance Claim Form. If Element 19 does not provide enough space for the description or if a provider is billing multiple unlisted procedure codes, documentation may be attached to the claim. In this instance, the provider should indicate "see attachment" in Element 19.

Timely Filing Appeals Requests

Requirements

When a claim or adjustment request meets one of the [exceptions](#) to the submission deadline, the provider is required to submit a [Timely Filing Appeals Request](#) form with a paper claim or an [Adjustment/Reconsideration Request](#) form to override the submission deadline.

DOS 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.

Resubmission

Decisions on [Timely Filing Appeals Requests](#) 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.

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](#) form.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

To receive consideration, a Timely Filing Appeals Request must be received before the deadline specified for the exception to the submission deadline.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS code, etc., as effective for the DOS. 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 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 level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request form.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
	The most recent claim number (also known as the ICN) must be indicated on the Adjustment/Reconsideration	

	Request form. This number may be the result of a ForwardHealth-initiated adjustment.	
Decision Made by a Court, Fair Hearing, or the 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 DHS.	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. A complete copy of the notice received from the court, fair hearing, or DHS must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 following documentation must be submitted within 455 days from the DOS: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ◦ White paper BadgerCare Plus EE for pregnant women or children identification card. ◦ Green paper temporary identification card. ◦ White paper PE for the FPW identification card. ◦ The response received through the EVS from a commercial eligibility vendor. ◦ The transaction log number received through WiCall. 	ForwardHealth Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when the local	To receive consideration, the request must be submitted	ForwardHealth

county or tribal agency requests a return of a GR payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following: <ul style="list-style-type: none"> • "GR retroactive enrollment" indicated on the claim. • A copy of the letter received from the local county or tribal agency. 	GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050
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Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	Documentation Requirements	Submission Address
<p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>To receive consideration, the following must be submitted within 90 days of the Medicare processing date:</p> <ul style="list-style-type: none"> • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim. 	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Refund Request from an Other Health Insurance Source		
Description of the Exception	Documentation Requirements	Submission Address
<p>This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.</p>	<p>To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification:</p> <ul style="list-style-type: none"> • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment. 	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Member Enrollment		
Description of the Exception	Documentation Requirements	Submission Address
<p>This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a member's retroactive enrollment.</p>	<p>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" must be indicated on the claim.</p>	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Coordination of Benefits

3

Archive Date:09/01/2010

Coordination of Benefits:Commercial Health Insurance

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (e.g., provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Commercial health insurance companies may permit reimbursement to the provider or member. Providers should verify whether commercial health insurance benefits may be assigned to the provider. As indicated by the commercial 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 commercial health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the commercial health insurance. In this instance providers should indicate the appropriate other insurance indicator. ForwardHealth will bill the commercial health insurance.

Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (e.g., request PA before providing the service for covered services that require PA). If the requirements are followed, BadgerCare Plus may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

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.

Commercial Managed Care

A commercial managed care plan provides coverage through a specified group of providers in a particular service area. The providers may be under contract with the commercial health insurance and receive payment based on the number of patients seen (i.e., capitation payment).

Commercial managed care plans require members to use a designated network of providers. Non-network providers (i.e., providers who do not have a contract with the member's commercial managed care plan) will be reimbursed by the commercial managed care 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 managed care plan, members enrolled in both a commercial managed care plan and BadgerCare Plus (i.e., state-contracted MCO, fee-for-service) are required to receive services from providers affiliated with the commercial managed care plan. In this situation, providers are required to refer the members to commercial managed care providers. This is necessary because commercial health insurance is always primary to BadgerCare Plus.

BadgerCare Plus will *not* reimburse the provider if the commercial managed care plan denied or would deny payment because a

service otherwise covered under the commercial managed care plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside his or her commercial managed care plan, the provider cannot collect payment from the member.

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.

Discounted Rates

Providers of services that are discounted by commercial health insurance should include the following on claims submitted:

- Their [usual and customary charge](#).
- The appropriate other insurance indicator.
- The amount, if any, actually received from commercial health insurance as the amount paid by commercial health insurance.

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
<p>If Wisconsin's EVS 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.</p> <p>If the member disputes the information as it is indicated in the EVS, the provider should submit a completed Other Coverage Discrepancy Report form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.</p>
Step 2. Determine if the Service Requires Other Health Insurance Billing
<p>If the service requires other health insurance billing, the provider should proceed to Step 3.</p> <p>If the service does not require other health insurance billing, the provider should proceed in one of the following ways:</p> <ul style="list-style-type: none"> • The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the BadgerCare Plus-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. <p>The provider may not bill BadgerCare Plus and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with BadgerCare Plus's ability to recover prior payments.</p>
Step 3. Identify Assignment of Commercial Health Insurance Benefits
<p>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.)</p> <p>The provider should proceed in one of the following ways:</p>

- **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.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from BadgerCare Plus and the member, the provider is required to return the lesser amount to BadgerCare Plus.

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. Commercial remittance information should not be attached to the claim.

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, BadgerCare Plus will pay for services covered by both BadgerCare Plus 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 "OI-Y" on paper claims.
- Refer to the Wisconsin [Provider Electronic Solutions Manual](#) or the appropriate [837 companion document](#) to determine the appropriate other insurance indicator for electronic claims.

Non-Reimbursable Commercial Managed Care Services

Providers are not reimbursed for the following:

- Services covered by a commercial managed care plan, except for coinsurance, copayment, or deductible.
- Services for which providers contract with a commercial managed care plan to receive a capitation payment for services.

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. Providers are required to use these indicators as applicable on claims 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.

Providers should not use other insurance indicators when the following occur:

- Wisconsin's EVS indicates no commercial health insurance for the DOS.
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI 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 [DHS 106.02\(9\)\(a\)](#), Wis. Admin. Code.

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.
- Family planning services.
- PNCC services.
- Preventive pediatric services.
- SMV services.

Services Requiring Commercial Health Insurance Billing

If the EVS indicates the code **"DEN"** for "Other Coverage," the provider is required to bill dental services to commercial health insurance before submitting claims to ForwardHealth.

If the EVS indicates that the member has Wausau Health Protection Plan (**"HPP"**), BlueCross & BlueShield (**"BLU"**), Wisconsin Physicians Service (**"WPS"**), TriCare (**"CHA"**), or some other (**"OTH"**) 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.
- Blood bank services.
- Chiropractic services.

- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over \$10.00 per item.
- Home health services (excluding PC 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.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- PT, OT, and SLP 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 services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 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 the EVS indicates the code "**VIS**" for "Other Coverage", the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If the EVS indicates the code "**HMO**" for "Other Coverage," 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.
- Blood bank services.
- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over \$10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient regardless of the type of hospital.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services billed for a member who has both Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- Pharmacy services for members with verified drug coverage.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician and physician assistant services.
- Podiatry services.
- PDN services for ventilator-dependent members.
- Radiology services.

- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 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 the EVS indicates Medicare Supplemental Plan Coverage ("**SUP**"), 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 service 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.

BadgerCare Plus has identified [services requiring Medicare billing](#).

Medicare

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](#) member is required to accept assignment of the member's Medicare Part B benefits. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount.

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.

Claims Processed by Commercial Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (e.g., 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.

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, 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.

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. Claims with an NPI 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 designated by ForwardHealth is required to identify the billing provider and 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 RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code designated by ForwardHealth and the ZIP+4 code of the practice location on file with ForwardHealth are required when an additional date is needed to identify the provider.

Claims for Services Denied by Medicare

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by BadgerCare Plus, the provider may submit a claim for those services directly to ForwardHealth. To allow payment by Wisconsin Medicaid in this situation, providers are encouraged to follow BadgerCare Plus requirements (e.g., request PA before providing the service for covered services that require PA). If the requirements are followed, Wisconsin Medicaid may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-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 regional carrier.
- Medicare Advantage 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.

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.

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 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 is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., 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 determined enrolled in BadgerCare Plus.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

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.
- Taxonomy code that is required by ForwardHealth.
- 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 through the ForwardHealth Provider Portal.
- 837I transaction, as applicable.
- 837P transaction, as applicable.
- PES software.
- Paper claim form.

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. Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., 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 (i.e., 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 services, OT services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

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, copayment, and deductible for Medicare-allowed services.
- BadgerCare Plus-covered services, even those that are not allowed by Medicare.

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](#) form, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.)

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- The claim is for a member who is enrolled in a Medicare Advantage Plan.
- 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 Medicare and commercial health insurance that is secondary to Medicare (e.g., 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, the provider is required to do the following:
 - Attach Medicare's remittance information and refrain from indicating the Medicare payment.
 - Indicate "MMC" in the upper right corner of the claim for services provided to members enrolled in a Medicare Advantage Plan.

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.

* 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](#) form. 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, 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. 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 BadgerCare Plus's procedures for submitting crossover claims.

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage was formerly known as Medicare Managed Care (MMC), Medicare + Choice (MPC), or Medicare Cost (Cost). Medicare Advantage Plans have a special arrangement with the federal CMS 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.

Paper Crossover Claims

Providers are required to indicate "MMC" in the upper right corner of provider-submitted crossover claims for services provided to members enrolled in a Medicare Advantage Plan. The claim must be submitted with a copy of the Medicare EOMB. This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

Crossover claims for Medicare Part B covered drugs for members enrolled in the Standard Plan, Medicaid, or SeniorCare with a Medicare Advantage plan will deny due to the Medicare Advantage plan being on the member's file. To be reimbursed, providers are required to submit a [Pharmacy Special Handling Request](#) and a [Noncompound Drug Claim](#). Providers should indicate the member is enrolled in a Medicare Advantage plan and indicate the Medicare Part B covered drug on the Pharmacy Special Handling Request.

Reimbursement Limits

Reimbursement limits on Medicare Part B services are applied to all Medicare Advantage Plan copayment amounts in accordance with federal law. This may reduce reimbursement amounts in some cases.

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 Wisconsin Medicaid constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by Wisconsin Medicaid 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.

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 [DHS 106.02\(9\)\(a\)](#), Wis. Admin. Code.

Medicare 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 [DHS 106.03\(6\)](#) and [106.03\(7\)\(b\)](#), Wis. Admin. Code, a provider is required to be enrolled in Medicare if both of the following are true:

- He or she provides a Medicare Part B service to a dual eligible.
- He or she 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 certified provider who is enrolled in Medicare.

To receive Medicaid reimbursement for a Medicare Part B service provided to a dual eligible, a provider who is not enrolled in Medicare but can be is required to apply for retroactive enrollment.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-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 certified provider who is enrolled in Medicare.

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 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 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 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: \$110.00.
- Allowed Amount: \$100.00.
- Coinsurance: \$20.00.
- Late Fee: \$5.00.
- Paid Amount: \$75.00.

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 \$5.00 to the paid amount of \$75.00 for a total of \$80.00. The claim should report the Medicare paid amount as \$80.00.

Medicare Retroactive Eligibility

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any Medicaid 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.

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier "CR" (Catastrophe/disaster related) on Medicare crossover claims (both [837P](#) transactions and 1500 Health Care Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only members affected by disasters. The [CMS Web site](#) contains more information.

National Provider Identifier and Related Data on Crossover Claims

An NPI and related data are required on crossover claims, in most instances. However, in some cases the taxonomy code designated by ForwardHealth may not be indicated on automatic crossover claims received from Medicare.

Secondary NPI

Medicare requires that certain subparts of an organization obtain separate NPIs and use the NPI for billing Medicare (e.g., hospital psychiatric unit). If an organization has identified subparts for the purpose of submitting claims to Medicare, and the NPIs appear on automatic crossover claims to ForwardHealth, ForwardHealth considers the NPIs submitted to Medicare to be secondary NPIs. ForwardHealth will process automatic crossover claims using secondary NPIs in cases where the provider has reported a secondary NPI to ForwardHealth. Along with the NPI, providers should also indicate the taxonomy and ZIP+4 code information.

Taxonomy Code Designated by ForwardHealth

The taxonomy code indicated on automatic crossover claims received from Medicare may be different than the taxonomy designated by ForwardHealth. Providers should resubmit the claim to ForwardHealth when the taxonomy code designated by ForwardHealth is required to identify the provider and is not indicated on the crossover claim received from Medicare.

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, copayment, and psychiatric reduction amounts at the detail level. If the Medicare coinsurance, copayment, 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 as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 transactions.

Paper Professional Crossover Claims Require Provider Signature

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form require a provider signature and date in Element 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.

Qualified Medicare Beneficiary-Only Members

QMB-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, copayment, 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.

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copayment of Medicare Part B services provided to dual eligibles and QMB-Only members.

Total payment for a Medicare Part B service (i.e., any amount paid by other health insurance sources, any copayment 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 copayment of a Medicare Part B service is the lesser of the following:

- The *Medicare*-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member.
- The *Medicaid*-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown

amounts paid by the member.

The following table provides examples of how the limitations are applied.

Reimbursement for Coinsurance or Copayment of Medicare Part B Services			
Explanation	Example		
	1	2	3
Provider's billed amount	\$120	\$120	\$120
Medicare-allowed amount	\$100	\$100	\$100
Medicaid-allowed amount (e.g., maximum allowable fee, rate-per-visit)	\$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.

Providers may use the following steps to determine how reimbursement was calculated:

1. Sum all of the detail Medicare paid amounts to establish the Claim Medicare paid amount.
2. Sum all of the detail Medicare coinsurance or copayment amounts to establish the Claim Medicare coinsurance or copayment amount.
3. Multiply the number of DOS by the provider's rate-per-visit. For example, \$100 (rate-per-visit) x 3 (DOS) = \$300. This is the Medicaid gross allowed amount.
4. Compare the Medicaid gross allowed amount calculated in step 3 to the Claim Medicare paid amount calculated in step 1. If the Medicaid gross allowed amount is less than or equal to the Medicare paid amount, Wisconsin Medicaid will make no further payment to the provider for the claim. If the Medicaid gross allowed amount is greater than the Medicare paid amount, the difference establishes the Medicaid net allowed amount.
5. Compare the Medicaid net allowed amount calculated in step 4 and the Medicare coinsurance or copayment amount calculated in step 2. Wisconsin Medicaid reimburses the lower of the two amounts.

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 transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop (2000A) and in the Rendering Provider Loop (2310B) 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 certifications. Providers should refer to the 837 companion documents for information on using taxonomy codes on standard claims transactions. ForwardHealth will accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop (2000A) and in the Rendering Provider Loop (2310B) and the billing and rendering providers are different.

This ForwardHealth requirement is inconsistent with the instructions in the 837P Implementation Guide; however, CMS has

acknowledged that health plans may need the billing provider taxonomy in order to accurately process claims.

Services Requiring Medicare Billing

If the EVS indicates Medicare + Choice ("MPC") for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory service center 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.

If the EVS indicates Medicare Cost ("MCC") for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Home health services (excluding PC services).
- Medicare-covered services.

ForwardHealth has identified [services requiring commercial health insurance billing](#).

Other Coverage Information

After Reporting Discrepancies

After receiving an [Other Coverage Discrepancy Report](#), 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 that the member's other coverage information has been updated.
- The provider receives a written explanation.

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.

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.

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 [Other Coverage Discrepancy Report](#) 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.

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the [Other Coverage Discrepancy Report](#) 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.

- 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 (e.g., the member does not live in the plan's service area).

Providers should not use the Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO.

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.

Provider-Based Billing

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. For example, a provider-based billing claim is created when BadgerCare Plus pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus 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 [DHS 106.03\(7\)](#), Wis. Admin. Code.

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) 221-4746. 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](#).

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.
- Provider-based billing claim(s). For each claim indicated on the Provider-Based Billing Summary, the provider will receive a prepared provider-based billing claim. This claim may be used to bill the other health insurance source; the claim includes all of the other health insurance source's information that is available.

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.

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus 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 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 that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (<i>do not</i> use the prepared provider-based billing claim).	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The provider discovers that the member's	<ul style="list-style-type: none"> • An Other Coverage Discrepancy Report form. 	Send the Other Coverage

other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	<ul style="list-style-type: none"> • 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 <i>not</i> use the prepared provider-based billing claim). 	<p>Discrepancy Report form to the address indicated on the form.</p> <p>Send the claim to the following address:</p> <p>ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002</p>
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	<ul style="list-style-type: none"> • A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source. 	<p>ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002</p>
The other health insurance source denies the provider-based billing claim.	<ul style="list-style-type: none"> • A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. 	<p>ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002</p>
The commercial health insurance carrier does not respond to an initial <i>and</i> follow-up provider-based billing claim.	<ul style="list-style-type: none"> • A claim according to normal claims submission procedures (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator. 	<p>ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002</p>

Beyond Claims Submission Deadlines

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or ended the other health insurance coverage from the member's file.	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	<p>ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050</p>
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	<ul style="list-style-type: none"> • An Other Coverage Discrepancy Report form. • <i>After</i> using the EVS to verify that the member's other coverage information has been updated, include both of the following: <ul style="list-style-type: none"> ◦ A claim (do <i>not</i> use the prepared provider-based billing claim.) ◦ A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	<p>Send the Other Coverage Discrepancy Report form to the address indicated on the form.</p> <p>Send the timely filing appeals request to the following address:</p> <p>ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050</p>
The commercial health insurance carrier reimburses or partially	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). 	<p>ForwardHealth Timely Filing</p>

reimburses the provider-based billing claim.	<ul style="list-style-type: none"> • Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	Ste 50 6406 Bridge Rd Madison WI 53784-0050
The other health insurance source denies the provider-based billing claim.	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: <ul style="list-style-type: none"> ◦ 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. • 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. 	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	<ul style="list-style-type: none"> • A claim (do <i>not</i> use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. 	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 that ForwardHealth has removed or ended 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 ended the other health insurance coverage from the member's file.	<ul style="list-style-type: none"> • 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 (i.e., enrollment dates) reported by the EVS is invalid.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • One of the following: <ul style="list-style-type: none"> ◦ The name of the person with whom the provider spoke and the member's correct other coverage information. ◦ A printed page from an enrollment Web site containing the member's correct other coverage information. 	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The DOS, 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. <p><i>Note:</i>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.</p>	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.	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: <ul style="list-style-type: none"> ◦ 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 documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. • 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. 	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance	<ul style="list-style-type: none"> • The Provider-Based Billing Summary. 	ForwardHealth

source fails to respond to the initial *and* follow-up provider-based billing claim.

- 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.

Provider-Based Billing
PO Box 6220
Madison WI 53716-0220
Fax (608) 221-4567

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 may use the claim prepared by ForwardHealth or produce his or her own claim. If the other health insurance source requires information beyond what is indicated on the prepared claim, the provider should add that information to the claim. The providers should also attach additional documentation (e.g., Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Billing Options

Providers may choose to seek payment from either of the following:

- Civil liabilities (e.g., injuries from an automobile accident).
- Worker's compensation.

However, as stated in [DHS 106.03\(8\)](#), Wis. Admin. Code, BadgerCare Plus will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS. 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.

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, 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.

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.

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, he or she 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 when services are provided to an accident victim on claims submitted to ForwardHealth. 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.

Covered and Noncovered Services

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Covered and Noncovered Services:Codes

Cochlear Implants

Providers should indicate the following procedure codes on PA requests and claims for cochlear implants. All procedure codes in this table are separately reimbursable for members residing in a nursing home. Refer to the DME [maximum allowable fee index](#) for maximum allowable fees.

Cochlear Implant Hearing Devices	
Code	Description
L7510	Repair of prosthetic device, repair or replace minor parts
L8614	Cochlear device, includes all internal and external components
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8619	Cochlear implant external speech processor, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each
L8623	Lithium ion battery for use with cochlear implant device speech processor; other than ear level, replacement, each
L8624	ear level, replacement, each

Replacement Parts for Cochlear Implants

The following cochlear implant device and bone-anchored hearing device replacement parts are reimbursable under procedure code L7510 (Repair of prosthetic device, repair or replace minor parts).

Cochlear Implant Devices	
Replacement Parts	Life Expectancy
Battery charger kit	1 per 3 years
Cochlear auxiliary cable adapter	1 per 3 years
Cochlear belt clip	1 per 3 years
Cochlear harness extension adapter	1 per 3 years
Cochlear signal checker	1 per 3 years
Microphone cover	1 per year
Pouch	1 per year

Diagnosis Codes

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

primary diagnosis.

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

Modifiers

Allowable modifiers for PT, OT, and SLP services are listed in the following table.

Therapy Discipline	Modifier	Description	Notes
Occupational therapy (OT)	GO	Services delivered [personally by an occupational therapist or] under an outpatient occupational therapy plan of care	
Physical therapy (PT)	GP	Services delivered [personally by physical therapist or] under an outpatient physical therapy plan of care	
PT and OT	TF	Intermediate level of care	"TF" should be indicated when submitting claims for services provided by physical therapist assistants or certified occupational therapy assistants under general supervision. "TF" should not be indicated on prior authorization (PA) requests.
PT, OT, and speech and language pathology	TL	Early intervention/Individualized Family Services Plan (IFSP)	"TL" should be indicated when submitting claims for Birth to 3 (B-3) services provided in the natural environment of a B-3 participant. "TL" should not be indicated on PA requests.

Reimbursement is only paid one time per day per discipline for physical therapy, occupational therapy, or speech therapy.

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.

Assistant therapist rendering providers are required to use the "TL" and "TF" modifiers.

Occupational Therapy Birth to 3 Procedure Codes

Allowable OT B-3 services are identified by the CPT and HCPCS procedures codes listed in the following table.

Procedure Code*	Description
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
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

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) (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) member contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) member contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) member contact by the provider, 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 by provider, each 15 minutes
*All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement.	

Occupational Therapy Procedure Codes

Covered OT services are identified by the allowable CPT and HCPCS procedures codes listed in the following table.

Evaluations			
Procedure Code	Description	Limit Per Day	Service May Be Provided by a Certified Occupational Therapy Assistant
97003	Occupational therapy evaluation	1 per day	No
97004	Occupational therapy re-evaluation	1 per day	No

Therapeutic Procedures			
Procedure Code	Description	Limit Per Day	Service May Be Provided by a Certified Occupational Therapy Assistant
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not applicable	Yes
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Not applicable	Yes
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not applicable	Yes
97139	Unlisted therapeutic procedure (specify)	Not applicable	Yes
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15	Not applicable	When appropriate*

	minutes		
97150	Therapeutic procedure(s), group (2 or more individuals)	Not applicable	Yes
97530	Therapeutic activities, direct (one-on-one) member contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Not applicable	Yes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) member contact by the provider, each 15 minutes	Not applicable	Yes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) member contact by the provider, each 15 minutes	Not applicable	Yes
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 by provider, each 15 minutes	Not applicable	Yes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Not applicable	Yes
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	1 per day	No
97598	Total wound(s) surface area greater than 20 square centimeters	1 per day	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	Not applicable	Yes

Modalities

Procedure Code	Description	Limit Per Day **	Service May Be Provided by a Certified Occupational Therapy Assistant
90901	Biofeedback training by any modality	Not applicable	Yes
97016	Application of modality to one or more areas; vasopneumatic devices	1 per day	Yes
97018	paraffin bath	1 per day	Yes
97022	whirlpool	1 per day	Yes
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	Not applicable	Yes
97033	iontophoresis, each 15 minutes	Not applicable	Yes
97034	contrast baths, each 15 minutes	Not applicable	Yes
97035	ultrasound, each 15 minutes	Not applicable	Yes

* When provided by certified occupational therapy assistants, Medicaid reimbursement is not available for myofascial release/soft tissue mobilization for one or more regions or joint mobilization for one or more areas (peripheral or spinal).

** The same modality may not be reimbursed as a PT service and an OT service on the same date of service for the same recipient.
Notes: 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.

Physical Therapy Birth to 3 Procedure Codes

Allowable PT B-3 services are identified by the CPT and HCPCS procedures codes listed in the following table.

Procedure Code*	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
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)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) member contact by the provider (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) member contact by the provider, 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 by the provider, each 15 minutes
* All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement.	

Physical Therapy Procedure Codes

Covered PT services are identified by the allowable CPT and HCPCS procedures codes listed in the following table.

Evaluations			
Procedure Code	Description	Limit Per Day	Service May Be Provided by a Physical Therapist Assistant
97001	Physical therapy evaluation	1 per day	No
97002	Physical therapy re-evaluation	1 per day	No

Modalities			
Procedure Code	Description	Limit Per Day*	Service May Be Provided by a Physical Therapist Assistant
	Electrical stimulation, (unattended), to one or more areas, for chronic stage		

G0281	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	1 per day	Yes
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	1 per day	Yes
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	1 per day	Yes
90901	Biofeedback training by any modality	Not applicable	Yes
97012	Application of a modality to one or more areas; traction, mechanical	1 per day	Yes
97016	vasopneumatic devices	1 per day	Yes
97018	paraffin bath	1 per day	Yes
97022	whirlpool	1 per day	Yes
97024	diathermy (eg, microwave)	1 per day	Yes
97026	infrared	1 per day	Yes
97028	ultraviolet	1 per day	Yes
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	Not applicable	Yes
97033	iontophoresis, each 15 minutes	Not applicable	Yes
97034	contrast baths, each 15 minutes	Not applicable	Yes
97035	ultrasound, each 15 minutes	Not applicable	Yes
97036	Hubbard tank, each 15 minutes	Not applicable	Yes
97039	Unlisted modality (specify type and time if constant attendance)	1 per day	Yes

Therapeutic Procedures			
Procedure Code	Description	Limit Per Day	Service May Be Provided by a Physical Therapist Assistant
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not applicable	Yes
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Not applicable	Yes
97113	aquatic therapy with therapeutic exercises	Not applicable	Yes
97116	gait training (includes stair climbing)	Not applicable	Yes
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not applicable	Yes
97139	Unlisted therapeutic procedure (specify)	Not applicable	Yes
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	Not applicable	When appropriate**
97530	Therapeutic activities, direct (one-on-one) member contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Not applicable	Yes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) member contact by the provider, each 15 minutes	Not applicable	Yes

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 by provider, each 15 minutes	Not applicable	Yes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Not applicable	Yes
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	1 per day	No
97598	total wound(s) surface area greater than 20 square centimeters	1 per day	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	Not applicable	Yes

Other Procedures			
Procedure Code	Description	Limit Per Day	Service May Be Provided by a Physical Therapist Assistant
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	1 per day	No
93798	with continuous ECG monitoring (per session)	1 per day	No
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	1 per day	No
94668	subsequent	1 per day	No

* The same modality may not be reimbursed as a PT service and an OT service on the same date of service for the same recipient.
 ** When provided by certified physical therapist assistants, Medicaid reimbursement is not available for myofascial release/soft tissue mobilization for one or more regions or joint mobilization for one or more areas (peripheral or spinal)
Notes: Procedure codes for many PT 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 PT services do not have a time increment indicated in their description. For these procedure codes, a quantity of "1" indicates a complete service.

Place of Service Codes

Allowable POS codes for PT, OT, and SLP are listed in the following table.

Place of Service Code	Description
04*	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12*	Home
15	Mobile Unit
20	Urgent Care Facility

21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Facilities for Developmental Disabilities
71	State or Local Public Health Clinic
72	Rural Health Clinic
99*	Other Place of Service

* Place of service 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.

Speech and Language Pathology Birth to 3 Procedure Codes

Allowable SLP B-3 services are identified by the CPT and HCPCS procedures codes listed in the following table.

Procedure Code	Description	Billing Limitations	Additional Conditions
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	Cannot use on the same DOS as 92510 or 96105.	This code is also used for re-evaluation.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	Cannot use on the same DOS as 92510.	Therapy addressing communication/cognitive impairments and voice prosthetics should use this code. If treatment focus is aural rehabilitation as a result of a cochlear implant, submit a prior authorization request using the PA/TA, to request code 92510.
92508	group, two or more individuals		Group is limited to two to four individuals.
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.
			This code describes the services to evaluate a patient for the use of a voice prosthetic device (e.g.,

92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Cannot use on the same DOS as 96105.	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 patient 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	This code can only be billed in conjunction with 92607.	A maximum of 90 minutes is allowable. The maximum allowable number of units for this service is one unit of 92607 and one unit of 92608.
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		

* 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.

Notes: All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement. As with Medicare, providers may not submit a claim for services for less than eight minutes. Most procedure codes for speech and language pathology services do not have a time increment indicated in their description. Except as noted above, a quantity of "1" indicates a complete service. The daily service limitation for these codes is one.

Speech and Language Pathology Procedure Codes

Covered SLP services are identified by the allowable CPT procedures codes listed in the following table.

Procedure Code	Description	Billing Limitations	Additional Conditions
31575	Laryngoscopy, flexible fiberoptic; 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 Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
31579	Laryngoscopy, flexible or rigid fiberoptic, 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.
92506	Evaluation of speech, language, voice, communication, and/or auditory processing	Cannot use on the same DOS as 96105.	This code is to be used for re-evaluation. Use this code for evaluation of auditory rehabilitation status.
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 speech/language pathology 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 HFS 101.03[69], Wis. Admin. Code).
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 (ie, aerodynamic testing and acoustic testing)		Use this code for laryngeal airflow studies, subglottic air pressure studies, acoustic analysis, EGG laryngeal resistance.
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 (e.g., 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 (i.e., 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.	
92700	Unlisted otorhinolaryngological service or procedure		PA 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.	

* 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.

Notes: All codes listed in this chart, if billed with an applicable 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 speech and language pathology 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.

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, equals one unit. For example, descriptions for 94667 (for PT and OT services) and 92612 (for SLP 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.)

Covered Services and Requirements

A Comprehensive Overview

Covered PT, OT, and SLP services are identified by the [PT](#), [OT](#), and [SLP](#) procedure codes compiled by BadgerCare Plus.

The [DME and DMS](#) 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 requirements, BadgerCare Plus Benchmark Plan service limitations, and claims submission instruction for DME/DMS services.

Basic Plan Covered Therapy Services

The Basic Plan covers the same PT, OT, and SLP services as the BadgerCare Plus Standard Plan.

Service Limitations for the Basic Plan

The Basic Plan covers up to 10 visits in each therapy discipline (PT, OT, and SLP) per member, per per [enrollment year](#). Cardiac rehabilitation visits are counted towards the 10 visits allowed for PT.

A therapy visit is defined as all therapy services delivered on the same date of service (DOS) by the same rendering provider.

Therapy visits in any discipline that exceed the Basic Plan service limitation are considered noncovered.

Basic Plan Enrollment Year

The Basic Plan enrollment year is the time period used to determine service limitations for members in the Basic Plan.

The Basic Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (the first day of the month) in the Basic Plan and ending on the last day of the 12th full calendar month.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Information for [DOS before August 15, 2009](#), is available.

Benchmark Plan Covered Therapy Services

PT, OT, and SLP services covered under the BadgerCare Plus Benchmark Plan are the same as those covered under the BadgerCare Plus Standard Plan.

Service Limitations

The Benchmark Plan covers up to 20 visits in each therapy discipline (PT, OT, and SLP) per member per enrollment year.

When these services are provided in schools, whether or not the services are reimbursed under the SBS benefit, they do not count toward the Benchmark Plan service limitation of 20 visits per enrollment year for each therapy discipline.

Cardiac Rehabilitation

The Benchmark Plan also covers up to 36 visits per member per enrollment year for cardiac rehabilitation provided by a physical therapist. This service corresponds with CPT procedure codes 93797 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring [per session]) and 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring [per session]). The cardiac rehabilitation visits will not be deducted from the 20 PT visits.

Bone-Anchored Hearing Aid and Cochlear Implant Surgeries

Effective August 1, 2010, the Benchmark Plan covers up to a maximum of 60 SLP therapy service visits over a 20-week period following bone-anchored hearing aid or cochlear implant surgery for members 17 years of age and younger. These visits do not count toward the Benchmark Plan service limitation of 20 visits per enrollment year for each therapy discipline.

A therapy visit is defined as all therapy services delivered on the same DOS by the same rendering provider.

Therapy visits in any discipline that exceed the Benchmark Plan service limitations are considered noncovered.

Benchmark Plan Enrollment Year

Under the BadgerCare Plus Benchmark Plan, an enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes her BadgerCare Plus application materials by September 25, 2008. During the month of October, the DHS reviews the application materials and determines that the member is eligible for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the BadgerCare Plus Standard Plan, the Benchmark Plan enrollment year does not reset. For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa. If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

Cochlear and Bone-Anchored Hearing Aid Surgeries

The rendering provider is required to obtain PA for the cochlear or bone-anchored hearing aid implant surgeries. ForwardHealth will deny claims for services relating to the surgery unless there is an approved PA request on file from the rendering surgeon for the

surgery. Effective August 1, 2010, surgeries for cochlear implants and bone-anchored hearing aids are covered under the BadgerCare Plus Benchmark Plan for members 17 years of age and younger.

The surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center *and* the surgeon is certified as a DME provider.

Core Plan Covered Therapy Services

The BadgerCare Plus Core Plan covers the same PT, OT, and SLP services as the BadgerCare Plus Standard Plan.

Service Limitations for the Core Plan

The Core Plan covers up to 20 visits in each therapy discipline (PT, OT, and SLP) per member per [enrollment year](#). Cardiac rehabilitation visits are counted under the 20 visits allowed for PT.

A therapy visit is defined as all therapy services delivered on the same DOS by the same rendering provider.

Therapy visits in any discipline that exceed the Core Plan service limitations are considered noncovered.

Core Plan Enrollment Year

The BadgerCare Plus Core Plan enrollment year is the time period used to determine service limitations for members in the Core Plan. Services received while covered under the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan do not count toward the enrollment year service limitations in the Core Plan and vice versa.

The Core Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (either the first or the 15th day of the month) in the Core Plan and ending on the last day of the 12th full calendar month.

The Core Plan enrollment year will reset if there is a gap in coverage for more than a full calendar month. For example, a member's situation changes for a few months and the member is temporarily ineligible for the Core Plan. More than one month later, the member becomes eligible again and re-applies for the Core Plan. When the member's application is approved and Core Plan coverage begins, the Core Plan enrollment year resets. Core Plan service limitations for this member also reset.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Enrollment Year for Members Switching Between the Core Plan and the Benchmark Plan

Special conditions apply to the enrollment year for members who switch between the Core Plan and the Benchmark Plan.

If a member is in the Core Plan and subsequently becomes eligible for and enrolls in the Benchmark Plan, his or her enrollment year in the Core Plan automatically ends. A new enrollment year under the Core Plan will begin if the member re-enrolls in the Core Plan at a later date.

If a member is in the Benchmark Plan, becomes temporarily eligible for and enrolls in the Core Plan, then switches back into the Benchmark Plan, the enrollment year for the Benchmark Plan will reset if there has been a gap in coverage for more than one full calendar month. If there has not been a gap in coverage for more than one full calendar month, and if the date of re-enrollment in the Benchmark Plan is within the initially established enrollment year dates, the Benchmark Plan enrollment year will not reset.

For example, a member is enrolled in the Benchmark Plan as of July 1, 2009. That member's Benchmark Plan enrollment year is

defined as July 1, 2009, through June 30, 2010. The member loses her eligibility for the Benchmark Plan as of September 30, 2009. The member applies for the Core Plan and her enrollment begins on October 15, 2009. (The gap in coverage for this member is less than one full calendar month.) The member becomes ineligible for the Core Plan and the member's enrollment ends on March 31, 2010. The member re-enrolls in the Benchmark Plan, effective April 1, 2010. (The date of re-enrollment in the Benchmark Plan is within the dates of the previous Benchmark Plan enrollment year.) The member's enrollment year under the Benchmark Plan does not reset and is still defined as July 1, 2009 through June 30, 2010.

Daily Limitations

For [PT](#), [OT](#), and [SLP](#) 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 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.

Definition of Covered Services

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

Duplicate Services

Duplicate services may not be reimbursed by Wisconsin Medicaid. Wisconsin Medicaid may deny payment when another provider has a valid PA for duplicate PT, OT, and SLP 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.

Durable Medical Equipment and Disposable Medical Supplies

Certain DME and DMS may be provided by PT, OT, and SLP 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.

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in [DHS 101.03\(52\)](#), Wis. Admin. Code, 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 or other program requirements may be waived in emergency situations.
- [Noncertified providers](#) may be reimbursed for emergency services.
- [Non-U.S. citizens](#) may be eligible for covered services in emergency situations.

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 for PT, OT, and SLP 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 when both are medically necessary.

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 (e.g., business ownership).
- The evaluation is not medically necessary (e.g., 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.

Group Therapy

Group therapy may be reimbursed by Wisconsin Medicaid for OT and SLP services but not for PT services.

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

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

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.

Information Regarding Evaluations

Frequently Asked Questions Regarding Evaluations

ForwardHealth covers evaluations for PT, OT, and SLP, 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 prior authorization (PA) 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: If a therapist has received a prescription to evaluate an individual, why might a PA request for the evaluation be denied?

A: ForwardHealth has a specific, legal definition of medical necessity. Although ForwardHealth requires that all services and equipment be prescribed by a physician, the physician's prescription alone does not meet ForwardHealth's specific, legal definition of medical necessity. Refer to [DHS 101.03\(96m\)](#), Wis. Admin. Code for standards applicable to PA requests for therapy services.

The following are examples of evaluations that are not medically necessary. Prior Authorization requests for these evaluations would not be approved for reimbursement by ForwardHealth:

- *A screening could have provided the same conclusions and recommendations as a comprehensive evaluation.*
- *The professional skills of a PT, OT, or SLP provider were not required to perform the evaluation.* The information obtained from the therapy evaluation must justify that a therapist was required to perform the evaluation. The consultant reviewing the PA request may consider one or more of the following questions to determine if the professional skills of a PT, OT, or SLP provider were necessary:
 - What tests or measures were used in the therapy evaluation that led to conclusions that were not known about the member before the evaluation?
 - Why is the therapy evaluation required to be completed? What is the purpose of the evaluation?
 - Do other reports or medical records include the same information about the member?
 - Could the member's medical needs be met, or have they already been met, by a person other than a therapist?
- *The evaluation was completed solely because of a change in one of the following circumstances:*
 - The member's commercial health insurance coverage. ForwardHealth will not reimburse an evaluation when the evaluation was completed because Medicare coverage, or coverage from any other pay source, has ended or changed.
 - The PT, OT, or SLP provider's employment status (e.g., business ownership). For example, if a therapist works for an agency and the agency is sold, providers will not be reimbursed because the services are being provided by a new agency when the therapist treating the member remains the same.
- *The reason for performing the evaluation was not medically necessary (e.g., an evaluation performed for the purpose of vocational training).* The requirement and purpose for performance of a service, such as a test or assessment, must be medically necessary, even if the professional skills of a therapist are needed to administer the service. A therapist may have special training or certification that allows the therapist to administer a particular test or assessment, but the need for the member to participate in the testing process must be medically necessary.

If the reason for referral or the requested therapy services is not medically necessary or is noncovered, the evaluation will not be reimbursed. Examples include, but are not limited to, the following:

- Therapy services for the member's participation in general gross motor activities, such as riding a bike or swimming, for the purpose of general health and wellness or weight loss.
- Therapy services for a program that has been declared experimental in nature, such as auditory integration training services.
- Assessments for the purpose of the member's participation in a vocational or recreational program, such as ergonomic evaluations, driving evaluations, or an evaluation to obtain a hunting license. Functional capacity evaluations are not covered by BadgerCare Plus.
- Evaluations performed so that a member is able to participate in a program that would not be covered, such as computer or video training, or treatment interventions that may be considered alternative therapies, such as aquatic programs with marine mammals.

- Evaluations completed solely to meet facility, agency, program, or clinic requirements (e.g., a therapy evaluation completed solely due to member age or at specified intervals of time).
- *The PT, OT, or SLP provider reports a change in the member's status, but the POC is not updated to reflect this change.* When a member is participating in a therapy program, the therapist continually assesses the member's condition and response to treatment interventions. If the member experiences a new illness or injury during the course of therapy, but the new diagnosis or clinical status does not result in significant changes to the therapy POC goals, providers will not be reimbursed for a therapy evaluation.

Note: Providers are reminded that a PA request for a therapy evaluation may also be denied for one of the following clerical reasons. The list includes examples that may be helpful to providers determining reimbursement of a therapy evaluation.

Examples are included, but the basic policy reasons for which PA may also be denied are not limited to the following:

- The PA request was not received by ForwardHealth within 14 calendar days of the initial therapy evaluation. An approved PA request may be backdated to the date of the initial therapy evaluation if the PA request is received within the 14-day limit. PA requests for ongoing therapy may not be backdated.
- The evaluation was not completed by a provider who was Medicaid-certified on the date of service.
- The evaluation was not complete and comprehensive. If the therapy evaluation is a summary of reports and records from other sources regarding the member's condition and status, the PA request may be denied or returned to the provider.
- The therapy evaluation was duplicative to another service. The standards of medical necessity stated in [DHS 101.03 \(96m\)](#), Wis. Admin. Code, define a duplicative service as not being medically necessary. If a member is receiving other therapy services in another setting or from another provider, the medical need for a second provider must be supported. Pursuant to [DHS 107.03 \(12\)](#), Wis. Admin. Code, a therapy evaluation performed for the purpose of a second opinion is not covered.
- The member was not eligible for BadgerCare Plus on the DOS.

Q: Does ForwardHealth Plus pay for screenings?

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

Q: Is a therapist able to bill the member if an evaluation is not paid by ForwardHealth?

A: A member may request a noncovered service, a covered service for which PA 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.

Additionally, the provider may not bill the member if the services are denied because of the provider's negligence to comply with ForwardHealth procedures, such as a PA request that is not received on time to backdate coverage to the date of the evaluation.

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. 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 treatment days covered by other health insurance sources or any treatment days provided by another provider in any setting. 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 treatment days must meet the same medical necessity requirements as PT, OT, and SLP services that require PA.

Medical Necessity

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

Member Payment for Covered Services

Under state and federal laws, a Medicaid-certified 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 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 certification.

Natural Environments

Federal regulations require that providers deliver all B-3 services in the child's [natural environment](#) to the maximum extent possible. B-3 services may be provided in a setting other than a natural environment only when outcomes cannot be satisfactorily achieved in the child's natural environment.

Program Requirements

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

To receive Medicaid reimbursement for a covered service, all Medicaid requirements must be met. For PT, OT, and SLP 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 before they are provided.
- Services are medically necessary as defined under [DHS 101.03\(96m\)](#), Wis. Admin. Code.
- Services are performed by a qualified provider and supervision requirements are met.
- Services are prescribed by a physician.
- Services are prior authorized by ForwardHealth, when applicable.

Resetting Service Limitations

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

- A fee-for-service member is enrolled in an HMO.

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

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

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

Resetting service limitations does not change a member's [Benchmark Plan](#) enrollment year or a member's [Core Plan](#) enrollment year.

Services That Do Not Meet Program Requirements

As stated in [DHS 107.02\(2\)](#), Wis. Admin. Code, BadgerCare Plus 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 [DHS 106.03](#), Wis.Admin. Code, 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 the DHS, the PRO 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 certification requirements under [DHS 105](#), Wis. Admin. Code.
- 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 the DHS.

HealthCheck "Other Services"

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT. HealthCheck services consist of a comprehensive health screening of members under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by or that exceed coverage limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary medical services are available to BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and Medicaid members under 21 years of age.

Prior Authorization

To receive PA for HealthCheck "Other Services," providers are required to [submit a PA request via the ForwardHealth Portal](#) or to submit the following via [fax](#) or [mail](#):

- A completed [PA/RF](#) (or [PA/DRF](#), or [PA/HIAS1](#)).
 - The provider should mark the checkbox titled "HealthCheck Other Services" at the top of the form.
 - The provider may omit the procedure code if he or she is uncertain what it is. The ForwardHealth consultant will assign one for approved services.
- The appropriate service-specific PA attachment.
- Verification that a comprehensive HealthCheck screening has been provided within 365 days prior to ForwardHealth's receipt of the PA request. The date and provider of the screening must be indicated.
- Necessary supporting documentation.

Providers may call [Provider Services](#) for more information about HealthCheck "Other Services" and to determine the appropriate PA attachment.

Requirements

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

- The condition being treated is identified in a HealthCheck screening that occurred within 365 days of the PA request for the service.
- The service is provided to a member who is under 21 years of age.
- The service may be covered under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently covered are not considered acceptable to treat the identified condition.

BadgerCare Plus 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 limitations are reasonable and maintain the preventive intent of the HealthCheck program.

Noncovered Services

Basic Plan Noncovered Services

The following are among the services that are not covered under the BadgerCare Plus Basic Plan:

- Case management.
- Certain visits over the 10-visit limit.
- Enteral nutrition.
- HealthCheck.
- Health education services.
- Hearing services, including hearing instruments, cochlear implants, and bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, private duty nursing).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, specialized medical vehicle).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- Prenatal care coordination.
- Provider administered drugs.
- Routine vision.
- School-based services.
- Transplants and transplant-related services.

Billing Members for Noncovered Services

Basic Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services. Basic Plan members do not have appeal rights for noncovered services.

Definition of Noncovered Services

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

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 the following:

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

Missed Appointments

The federal CMS 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.
- Encourage the member to call his or her local county or tribal agency if transportation is needed.
- 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 Services

Translation services 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.

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

Managed Care

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Managed Care:Claims

Appeals to BadgerCare Plus and Wisconsin Medicaid

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the HMO or SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response.

BadgerCare Plus or Wisconsin Medicaid will not review appeals that were not first made to the HMO or SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the HMO or SSI HMO, the appeal will be returned to the provider.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date of service in question.

Appeals must be made in writing and must include:

- A letter, clearly marked "APPEAL," explaining why the claim should be paid or a completed [Managed Care Program Provider Appeal](#) form.
- A copy of the claim, clearly marked "APPEAL."
- A copy of the provider's letter to the HMO or SSI HMO.
- A copy of the HMO's or SSI HMO's response to the provider.
- Any documentation that supports the case.

The appeal will be reviewed and any additional information needed will be requested from the provider or the HMO or SSI HMO. Once all pertinent information is received, BadgerCare Plus or Wisconsin Medicaid has 45 calendar days to make a final decision.

The provider and the HMO or SSI HMO will be notified in writing of the final decision. If the decision is in favor of the provider, the HMO or SSI HMO is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties must abide by the decision.

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO or Medicaid SSI HMO within 60 calendar days of receipt of the initial denial. Providers are required to include a letter explaining why the HMO or SSI HMO should pay the claim. The appeal should be sent to the address indicated on the HMO's or SSI HMO's denial notice.

The HMO or SSI HMO then has 45 calendar days to respond in writing to the appeal. The HMO or SSI HMO decides whether to pay the claim and sends the provider a letter stating the decision.

If the HMO or SSI HMO does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO's or SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days.

Claims Submission

BadgerCare Plus HMOs and Medicaid SSI HMOs have requirements for timely filing of claims, and providers are required to follow HMO and SSI HMO claims submission guidelines. Contact the enrollee's HMO or SSI HMO for organization-specific submission deadlines.

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO or Medicaid SSI HMO enrollee that have been denied by an HMO or SSI HMO 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 or SSI HMO at the time he or she was admitted to an inpatient hospital, but then enrolled in an HMO or SSI HMO during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. These claims (including physician claims) must include admittance and discharge dates.
- The claims are for orthodontia/prosthodontia services that began before HMO or SSI HMO coverage. Include a record with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, 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.

Submit extraordinary claims to:

ForwardHealth
 Managed Care Extraordinary Claims
 PO Box 6470
 Madison WI 53716-0470

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 HMO or Medicaid SSI HMO. Before submitting claims to HMOs and SSI HMOs, providers are required to submit claims to other health insurance sources. Contact the enrollee's HMO or SSI HMO for more information about billing other health insurance sources.

Provider Appeals

When a BadgerCare Plus HMO or Medicaid SSI HMO denies a provider's claim, the HMO or SSI HMO is required to send the provider a notice informing him or her of the right to file an appeal.

An HMO or SSI HMO network or non-network provider may file an appeal to the HMO or SSI MCO when:

- A claim submitted to the HMO or SSI HMO is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO or SSI HMO *before* filing an appeal with ForwardHealth.

Covered and Noncovered Services

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although BadgerCare Plus 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.

Noncovered Services

The following are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CSP benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC services.
- Pharmacy services and some drug-related supplies.
- PNCC services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, procedure code S4993 (Contraceptive pills for birth control), and a limited number of related [administration codes](#).
- SBS.
- Targeted case management services.
- Transportation by common carrier (unless the HMO has made arrangements to provide this service as a benefit). Milwaukee HMOs and SSI HMOs are mandated to provide transportation for their enrollees.
- Directly observed therapy and monitoring for TB-only.

Enrollment

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 the member's HMO or SSI HMO. For example, in certain circumstances, women in high-risk pregnancies or women who are in the third trimester of pregnancy when they are enrolled in an HMO or SSI HMO *may* qualify for an exemption.

The [contracts](#) between the DHS and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

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 the DHS and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan are eligible for enrollment in a BadgerCare Plus HMO. BadgerCare Plus Core Plan members are enrolled in BadgerCare Plus HMOs.

An individual who receives the FPW program, the TB-Only benefit, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and commercial health insurance coverage may be verified by using Wisconsin's [EVS](#) 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.

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled, enrollees 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, he or she will be disenrolled from the HMO.

SSI HMOs

Members are sent enrollment packets that explain the Medicaid SSI HMO's enrollment process and provide contract information. Once enrolled, enrollees may disenroll after a 60-day trial period and up to 120 days after enrollment and return to Medicaid fee-for-service if they choose.

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.

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.

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.

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Release of Billing or Medical Information

BadgerCare Plus supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. BadgerCare Plus has [specific standards](#) regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

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 BadgerCare Plus (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, claims submission, adjudication procedures, etc., which may differ from BadgerCare Plus fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the several special managed care programs available.

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.

Managed Care Contracts

The contract between the DHS and the BadgerCare Plus HMO or Medicaid SSI HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by the DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI HMOs. If there is a conflict, the HMO or SSI HMO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI HMO contracts can be found on the Managed Care Organization area of the ForwardHealth Portal.

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g. medical, dental, mental health/substance abuse, vision, and prescription drug coverage) at no cost to their enrollees through a care management model. Medicaid members and SSI-related Medicaid members in certain counties 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

Members who meet the following criteria are eligible to enroll in an SSI HMO:

- Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program.
- Individuals ages 19 and older.

- Individuals who are enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid.

Individuals who are living in an institution or nursing home or are participating in a home and community-based waiver program or FamilyCare are not eligible to enroll in an SSI HMO.

Ozaukee and Washington Counties

Most SSI and SSI-related Medicaid members who reside in Ozaukee and Washington counties are required to choose the HMO in which they wish to enroll. Dual eligibles (members receiving Medicare and Wisconsin Medicaid) are not required to enroll. After a 60-day trial period and up to 120 days after enrollment, enrollees may disenroll and return to Medicaid fee-for-service if they choose.

Southwestern Wisconsin Counties

SSI members and SSI-related Medicaid members who reside in Buffalo, Jackson, La Crosse, Monroe, Trempealeau, and Vernon counties may choose to receive coverage from the HMO or remain in Wisconsin Medicaid fee-for-service.

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 60 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 that is currently approved by Wisconsin Medicaid. The PA must be honored for 60 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.
- Coverage of drugs that an SSI member is currently taking until a prescriber orders different drugs.

Special Managed Care Programs

Wisconsin Medicaid has several special managed 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, the PACE, and the Family Care Partnership Program. Additional information about these special managed care programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Prior Authorization

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA 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.

Provider Information

Copayments

Providers cannot charge Medicaid SSI HMO enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply.

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 the DHS 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 CFR s. 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.

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 DHS 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.

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.

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.

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.

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO's or Medicaid SSI HMO's benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-certified provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

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Archive Date:09/01/2010

Member Information:Birth to 3 Program

Administration and Regulations

In Wisconsin, B-3 services are administered at the local level by county departments of community programs, human service departments, public health agencies, or any other public agency designated or contracted by the county board of supervisors. The DHFS monitors, provides technical assistance, and offers other services to county B-3 agencies.

The enabling federal legislation for the B-3 Program is 34 CFR Part 303. The enabling state legislation is s. [51.44](#), Wis. Stats., and the regulations are found in ch. [DHS 90](#), Wis. Admin. Code.

Providers may contact the appropriate [county B-3 agency](#) for more information.

Eligibility Criteria

A child from birth up to (but not including) age three is eligible for B-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 percent 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.

BadgerCare Plus includes B-3 information in this handbook because many B-3 participants are also Medicaid recipients who receive PT, OT, or SLP services.

Individualized Family Services Plan

A B-3 member receives an IFSP developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, and services appropriate to meet the needs of the child and family and the natural environment settings where services will be provided. All B-3 services must be identified in the child's IFSP.

According to B-3 Program requirements, the child's IFSP service coordinator is responsible for facilitating the development of the IFSP, based on team decisions and consensus. The service coordinator is expected to assure IFSP development in a timely manner and to provide all team members with a full copy of the completed IFSP.

The county B-3 program is responsible for ensuring that the following are true:

- Evaluation, service coordination, IFSP development, and protection of rights have no cost to the parents or guardians.
- Other services identified under [DHS 90.11\(4\)](#), Wis. Admin. Code, are provided in accordance with the IFSP.

The county B-3 program determines parental liability for the cost of the program in accordance with state administrative guidelines.

Procedures to Follow when Consent Is Given to Bill the

Commercial Health Insurance

When a child's parents or guardians give consent to billing their commercial health insurance (or when the child has no commercial health insurance coverage), federal and state regulations require the provider to submit claims in the following order:

1. Bill the commercial health insurance with the informed, written consent of the child's parents or guardians if applicable.
2. Submit claims to ForwardHealth.
3. Bill the county B-3 agency (according to the agency's requirements) if ForwardHealth does not cover the services.

Procedures to Follow when the Birth to 3 Agency Pays the Commercial Health Insurance Liability

Federal regulations (34 CFR Part 303) allow a B-3 member's parents or guardians to refuse consent to bill their commercial health insurance if it would result in a cost to the family, such as:

- Reaching the lifetime limit on a policy.
- An increase in premiums, copayments, or deductibles.

B-3 agencies may reimburse the commercial health insurance liability when both of the following occur:

- The BadgerCare Plus member participates in the B-3 Program and is receiving B-3 services.
- The parents or guardians do not allow their Medicaid provider or Medicaid managed care program to bill their commercial health insurance first.

These procedures do not apply when the following occur:

- The member is not covered by commercial health insurance.
- The parents or guardians give consent to submit claims to their commercial health insurance.
- The services are not B-3 services.

When a county B-3 program pays the commercial health insurance liability, the provider is required to follow normal claims submission procedures to submit the balance of the charges to Wisconsin Medicaid.

- Step 1** The provider identifies the billed amount per month per therapy discipline.
- Step 2** The provider submits the claim to the county B-3 program.
- Step 3** The county B-3 program identifies the monthly commercial health insurance liability amount per discipline. The amounts are as follows:
- \$127 for PT services.
 - \$118 for OT OT services.
 - \$106 for SLP SLP services.

For any month in which the monthly billed amount is less than the monthly commercial health insurance liability amount, the county B-3 program pays the entire amount owed up to the commercial health insurance liability for that therapy discipline.

- Step 4** The county B-3 program pays the commercial health insurance liability amount. When reimbursing the provider, the county B-3 program should send copies of:
- The EOB notice.
 - The invoice.

When the provider works for the county B-3 program, the provider should clearly identify the accounting transactions in the agency's records. Providers should retain the EOB notice in the recipient's record.

- Step 5** When submitting the claim to Wisconsin Medicaid, the provider should indicate his or her usual and customary charge, the amount paid by the B-3 agency, and the appropriate other insurance indicator to indicate that the commercial liability was received.

Provision of Services in Natural Environment

Federal regulations require that providers deliver all B-3 services in the child's "natural environment," to the maximum extent possible. "Natural environment" is defined in both 34 CFR Part 303 and [DHS 90.03\(25\)](#), Wis. Admin. Code, as "settings that are natural or normal for the child's age peers who have no disability." In addition to a family home, natural environments may include family child care, community settings (e.g., YMCA), early childhood education settings, inclusive child care centers, or other settings where most of the children do not have disabilities. Natural environments do not include medical facilities such as therapy clinics, physician clinics, rehabilitation agencies, outpatient hospitals, or other center-based settings where most of the participating children have disabilities. The child's IFSP team determines which settings are appropriate for the delivery of B-3 services based on the needs of the child. Services should be provided in the places where the child's family and other caregivers can be present and learn therapy approaches. Carryover also occurs when approaches are integrated into the day-to-day activities of the child and family.

B-3 services may be provided in a setting other than a natural environment only when outcomes cannot be satisfactorily achieved in the child's natural environment. When services are not provided in a natural environment, the IFSP must include a justification of the extent to which services will be provided in an alternative setting.

BadgerCare Plus PT, OT, and SLP providers receive an enhanced reimbursement when PT, OT, or SLP services are provided in the natural environment of a B-3 participant. To receive the enhanced reimbursement, providers are required to indicate the "TL" modifier when submitting claims for services provided in the natural environment.

Requirements for Providers

Title 34 CFR Part 303 for B-3 services requires all health, social service, education, and tribal programs receiving federal funds, including Medicaid providers, to do the following:

- Identify children who may be eligible for B-3 services. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. Refer these children to the appropriate county B-3 program within two working days of identification. For example, if a provider's health exam or developmental screen indicates that a child may have a qualifying disability or developmental delay, the child must be referred to the county B-3 program for evaluation. (Providers are encouraged to explain the need for the B-3 referral to the child's parents or guardians.)
- Cooperate and participate with B-3 service coordination as indicated in the child's IFSP.
- Deliver B-3 services in the child's natural environment, unless otherwise specified in the IFSP.
- Assist parents or guardians of children receiving B-3 services to maximize their child's development and participate fully in implementation of their child's IFSP.

Enrollment Categories

BadgerCare Expansion for Certain Pregnant Women

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, 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 Expansion for Certain Pregnant Women 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 county/tribal social or human services 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 (e.g., claims submission procedures, PA 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 (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is a self-funded plan that focuses on providing BadgerCare Plus Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan are covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

Applicant Enrollment Requirements

Applicants are required to apply for the Core Plan and be put on the waitlist before they can enroll in the Basic Plan. The applicant must meet the following program requirements to enroll in the Core Plan and thus qualify for the Core Plan waitlist and the Basic Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. Applicants may be enrolled in the FPW or TB-Only).
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months unless there is justifiable cause.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

Individuals who wish to enroll in the Basic Plan must first apply for the Core Plan online at access.wi.gov/ or via a toll-free telephone number. A pre-screening tool at access.wi.gov/ will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members are processed by the [ESC](#), not by county agencies.

Once the Core Plan application process is complete and the individual has been placed on the waitlist for the Core Plan, the individual will have the option to enroll in the Basic Plan. An informational letter will be mailed to individuals on the waitlist with Basic Plan information and a coupon the individual can use to request enrollment in the Basic Plan and submit their initial premium payment. Members of the Basic Plan will be required to pay a monthly premium of approximately \$130.00 to maintain coverage. Members who fail to pay the monthly premium will have their Basic Plan coverage terminated and will be subject to a restrictive re-enrollment period, which will not allow the member to re-enroll for 12 months. Termination of Basic Plan coverage does not affect a member's status on the Core Plan waitlist or his or her eligibility for the Core Plan if room becomes available.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, the Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD.
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to [Member Services](#) for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card.

Basic Plan Member Fact Sheets

[Fact sheets](#) providing additional member information about the Basic Plan are available.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the HIRSP as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Information that is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool is [available](#).

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under the FPW or those benefits provided to individuals who qualify for TB-Only.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan [using the Access tool online](#) or via the [ESC](#). A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of \$60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-certified providers cannot pay the \$60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ and the Department of HHS's OIG.

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD.
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the ESC at (800) 291-2002 for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. For members enrolled in the Core Plan, HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

BadgerCare Plus Standard Plan and Benchmark Plan

BadgerCare Plus is a state-sponsored health care program that expands coverage of Wisconsin residents and ensures that all children in Wisconsin have access to affordable health care.

The key initiatives of BadgerCare Plus are:

- To ensure that all Wisconsin children have access to affordable health care.
- To ensure that 98 percent of Wisconsin residents have access to affordable health care.
- To streamline program administration and enrollment rules.
- To expand coverage and provide enhanced benefits for pregnant women.
- To promote prevention and healthy behaviors.

BadgerCare Plus expands enrollment in state-sponsored health care to the following:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

Where available, BadgerCare Plus members will be 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.

Basic Plan Members Diagnosed with Cancer

Members enrolled in the BadgerCare Plus Basic Plan who are diagnosed with cancer, excluding non-melanoma skin cancers, may bypass the waitlist and apply for the BadgerCare Plus Core Plan. The diagnosis of cancer may be a new diagnosis since the member was enrolled in the Basic Plan or it may be a pre-existing condition.

Application Process for Basic Plan Members with Cancer

To enroll a Basic Plan member diagnosed with cancer in the Core Plan, a physician or osteopath who has diagnosed the member with cancer is required to complete the Core Plan Waitlist Medical Bypass Determination form. The provider is required to indicate a description of the type of cancer on the form.

Note: Basic Plan members with a diagnosis of one of the non-melanoma skin cancers are not eligible to apply for the Core Plan through the Core Plan waitlist bypass process.

The form must be submitted to the ESC by fax at (888) 415-2002 or by mail to the following address:

Enrollment Services Center
PO Box 7190
Madison WI 53707-7190

Providers are encouraged to submit completed forms by fax to ForwardHealth to avoid delays in mailing of forms.

A copy of the completed Core Plan Waitlist Medical Bypass Determination should be kept in the member's medical record.

Enrollment Process

After the completed Core Plan Waitlist Medical Bypass Determination form is received by ForwardHealth, the ESC will verify the

information on the form and contact the member to complete the application process via telephone. If the member cannot be reached via telephone, a letter will be mailed to encourage him or her to complete the application process. If the member is eligible for the Core Plan, enrollment will begin on the next first or fifteenth day of the month after the application is approved. The enrollment process is designed to ensure there is no gap in coverage during a member's transition from the Basic Plan to the Core Plan.

If the member does not meet eligibility criteria for the Core Plan, a notice of denial will be mailed to the member and enrollment in the Basic Plan will be terminated since the eligibility criteria for the Core Plan and the Basic Plan are the same.

The usual application processing fee for the Core Plan does not apply to members who have been diagnosed with cancer who will transition from the Basic Plan to the Core Plan. The member's most recent premium paid for the Basic Plan is applied as the enrollment fee for the Core Plan.

Members Enrolled in the Wisconsin Well Woman Program and the Basic Plan

Women may be enrolled in the WWWP and the Basic Plan at the same time. Women who are diagnosed with breast cancer or cervical cancer while enrolled in WWWP are eligible to be enrolled in WWWMA through the WWWP. WWWMA covers the same services as Wisconsin Medicaid; therefore, enrollment in WWWMA enables members to receive comprehensive treatment, including services not related to their diagnosis.

Once a woman is enrolled in WWWMA, she is no longer eligible for the Basic Plan. If the woman becomes ineligible for WWWMA in the future, she may be eligible to receive benefits from the Basic Plan.

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of four benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

BadgerCare Plus Standard Plan

The Standard Plan covers children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes at or below 200 percent of the FPL. The services covered under the Standard Plan are the same as the Wisconsin Medicaid program.

BadgerCare Plus Benchmark Plan

The Benchmark Plan was adapted from Wisconsin's largest commercial, low-cost health care plan. The Benchmark Plan is for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed parents, such as farmers with incomes above 200 percent of the FPL. The services covered under the Benchmark Plan are more limited than those covered under the Wisconsin Medicaid program.

BadgerCare Plus Core Plan

The Core Plan provides adults who were previously not eligible to enroll in state and federal health care programs with access to basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

BadgerCare Plus Basic Plan

The Basic Plan provides Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option allows members to have some form of minimal coverage until space becomes available in the Core Plan.

Express Enrollment for Children and Pregnant Women

EE 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.

To determine enrollment for EE for Pregnant Women, providers should use the income limits for 200 percent and 300 percent of the [FPL](#).

The EE for Children Benefit allows certain members under 18 years of age to receive BadgerCare Plus benefits under the BadgerCare Plus Standard Plan 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 county/tribal office.

Family Planning Waiver

The FPW is a limited benefit program that provides routine contraceptive-related services to low-income individuals age 15 through 44 who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving FPW services must be receiving routine contraceptive-related services.

The goal of the FPW 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 the FPW to members and encourage them to contact their local county or tribal agency to determine their enrollment options if they are not interested in receiving, or do not wish to receive, contraceptive services.

Members enrolled in the FPW receive routine services to prevent or delay pregnancy. In addition, FPW members may receive certain reproductive health services if the services are determined medically necessary during contraceptive-related FPW services. Only services *clearly* related to contraceptive management are covered under the FPW.

Providers should inform members about other service options and provide referrals for care not covered by the FPW.

FPW members are not eligible for other services that are covered under full-benefit Medicaid and BadgerCare Plus (e.g., PT services, dental services). Even if a medical condition is discovered during a contraceptive-related FPW service, treatment for the condition is not covered under the FPW unless the treatment is identified in the list of [allowable procedure codes](#) for FPW services. They are also not eligible for other family planning services that are covered under full-benefit Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-related services, treatment for the medical condition is not covered under the FPW.

Colposcopies and treatment for STDs are only covered through the FPW if they are determined medically necessary during routine contraceptive-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 in the FPW program and receiving contraceptive-related services.

FPW 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 service options and provide referrals for care not covered by FPW.

Temporary Enrollment for the Family Planning Waiver

Members whose providers are submitting an initial FPW application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE for the FPW for up to three months. Services covered under the TE for the FPW are the same as those covered under the FPW and must be clearly related to routine contraceptive management.

To determine enrollment for the FPW, providers should use the income limit for 200 percent of the [FPL](#).

TE for the FPW providers may issue white paper TE for BadgerCare Plus FPW Plan temporary identification cards for members to use until they receive a ForwardHealth identification card. Providers should remind members that the benefit is temporary, despite their receiving a ForwardHealth card.

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS 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.
- WCDP.
- WIR.
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP.

ForwardHealth interChange is supported by the state's fiscal agent, HP.

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Expansion for Certain Pregnant Women.
- EE for Children.
- EE for Pregnant Women.
- FPW, including the PE for the FPW.
- QDWI.
- QI-1.
- QMB Only.
- SLMB.
- TB-Only Benefit.

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 BadgerCare Plus Expansion for Certain Pregnant Women, FPW, EE for Children, EE for Pregnant Women, or the TB-Only Benefit 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 the FPW and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS 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.

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, MA, 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 ch. [49](#), Wis. Stats.

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 he or she is 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.
- [Subsidized adoption](#) and foster care programs.
- SSI.
- WWWP.

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:

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA 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.

Qualified Disabled Working Individual Members

QDWI 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 local county or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB Only and SLMB.

Qualified Medicare Beneficiary-Only Members

QMB-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, copayment, and deductible for Medicare-allowed services.

QMB-Only members are certified by their local county or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Qualifying Individual 1 Members

QI-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 local county or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Specified Low-Income Medicare Beneficiaries

SLMB 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 local county or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Tuberculosis-Related Services-Only Benefit

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

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 or the FPW, 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 Well Woman Medicaid are reimbursed through Medicaid fee-for-service.

Members Enrolled into Wisconsin Well Woman Medicaid from Benchmark Plan or Core Plan

Women diagnosed with breast cancer or cervical cancer while enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan for Adults with No Dependent Children are eligible to be enrolled in Wisconsin Well Woman Medicaid. Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid and enables members to receive comprehensive treatment, including services not related to their diagnosis.

Women who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix must have the diagnosis of their condition confirmed by one of the following Medicaid-certified providers:

- Nurse practitioners, for cervical conditions only.
- Osteopaths.
- Physicians.

Women with Medicare or other insurance that covers treatment for her cancer are not allowed to be enrolled into WWWMA.

Covered and Noncovered Services

Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid regardless of whether the service is related to her cancer treatment.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in WWWMA at the Wisconsin Medicaid rate of reimbursement for covered services. Providers are required to reimburse members for any copayments members paid on or after the date of diagnosis while still enrolled in the Benchmark Plan or the Core Plan.

Copayments

There are no copayments for any Medicaid covered service for WWWMA members who have been enrolled into WWWMA from the Benchmark or the Core Plan.

Enrollment Responsibilities

General Information

Members have certain responsibilities per [DHS 104.02](#), Wis. Admin. Code, and the [Medicaid Enrollment and Benefits](#) booklet or the [BadgerCare Plus Enrollment and Benefits](#) booklet.

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 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](#) or the ForwardHealth Portal prior to providing each service, even if an approved PA request is obtained for the service.

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.

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS that services are provided. Pursuant to [DHS 104.02\(2\)](#), Wis. Admin. Code, a member should inform providers that he or she is 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 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.

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 his or her ForwardHealth card](#),

providers may verify enrollment without it.

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.

Enrollment Rights

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus or Medicaid 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.

Pursuant to [HA 3.03](#), Wis. Admin. Code, 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 or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus 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 form](#).

Claims for Appeal Reversals

If a claim is denied due to termination of 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
 6406 Bridge Rd
 Madison WI 53784-0050

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.

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted MCO or assigned to the [Pharmacy Services Lock-In Program](#).

General Information

Members are entitled to certain rights per [DHS 103](#), Wis. Admin. Code.

Notification of Discontinued Benefits

When the DHS intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, the 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.

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.

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 members.

Identification Cards

ForwardHealth Basic Plan Identification Cards

Members enrolled in the BadgerCare Plus Basic Plan will receive a [ForwardHealth Basic Plan card](#). All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe readers, and the 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call Member Services at 1-800-362-3002 with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.

ForwardHealth Core Plan Identification Cards

Members enrolled in the BadgerCare Plus Core Plan will receive a [ForwardHealth Core Plan card](#). All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Core Plan members should call the ESC with questions about enrollment criteria, HMO enrollment, and covered services. The ForwardHealth Core Plan cards include the Enrollment Services Center telephone number, (800) 291-2002, on the back.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

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.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on his or her 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 he or she does 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](#).

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, he or she may call Member Services to request a new one.

If a member lost his or her 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 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.

Temporary Enrollment for BadgerCare Plus Family Planning Waiver Plan Temporary Cards

Qualified providers may issue white paper TE for BadgerCare Plus FPW Plan identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for BadgerCare Plus FPW Plan Application.

The TE for the FPW identification cards have the following message printed on them: "BadgerCare Plus Temporary Identification Card for Temporary Enrollment for the Family Planning Waiver Plan." Providers should accept the white TE for the FPW identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Temporary Express Enrollment Cards

There are two types of temporary EE identification cards. One is issued for pregnant women and the other for children that are enrolled in BadgerCare Plus through EE. The EE cards are valid for 14 days. [Samples](#) of temporary EE cards for children and pregnant women are available.

Providers may assist pregnant women with filling out an application for temporary ambulatory prenatal care benefits (formerly known as PE) through the online EE process. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. The beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process. A [sample](#) of an EE temporary card from the back of the EE application is available.

The online EE process is also available for adults to apply for full BadgerCare Plus benefits for children. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed. This temporary identification card is different, since providers may see more than one child listed if multiple children in one household are enrolled through EE. However; each child will receive his or her own ForwardHealth card after the application is submitted.

Each member who is enrolled through EE will receive a ForwardHealth card usually within three business days after the EE application is submitted and approved. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards. Providers may use Wisconsin's EVS to verify enrollment for DOS after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Information is available for [DOS before April 1, 2009](#).

Temporary ForwardHealth Identification Cards

All Medicaid certifying agencies have the authority to issue [green paper temporary identification cards](#) to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should accept temporary cards as proof of enrollment. Eligible applicants may receive covered services for the dates shown on the card.

Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the

enrollment start date until the enrollment information is transmitted to ForwardHealth.

ForwardHealth accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS is within the dates shown on the card.

If a claim is denied with an enrollment-related explanation, even though the provider verified the member's enrollment before providing the service, a [good faith claim](#) may be submitted.

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be in any of the following formats:

- White plastic ForwardHealth cards.
- White plastic ForwardHealth Core Plan cards.
- White plastic ForwardHealth Basic Plan cards.
- Green paper temporary cards.
- Paper printout temporary card for EE for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE for the FPW cards.

Misuse and Abuse of Benefits

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in [DHS 104.02\(5\)](#), Wis. Admin. Code.

Notifying ForwardHealth

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card. Section [49.49](#), Wis. Stats., defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are doing so. A provider may not confiscate a ForwardHealth card from a member in question.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling [Provider Services](#) or by writing to the following office:

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

ForwardHealth monitors member records and can impose sanctions on those who misuse or abuse their benefits. For more information on member misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

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 Wisconsin Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly prescriptions for controlled substances.

Coordination of member health care services is intended to do the following:

- 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 controlled substance medications. Abuse or misuse is defined under Recipient Duties in [DHS 104.02\(5\)](#), Wis. Admin. Code. The abuse and misuse definition includes, but is not limited to, the following:

- Duplicating or altering prescriptions.
- Feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service.
- Seeking duplicate care from more than one provider for the same or similar condition.
- Seeking medical care that is excessive or not medically necessary.

Members enrolled in the Pharmacy Services Lock-In Program are assigned to one primary care provider and one pharmacy to reduce

unnecessary physician and pharmacy utilization and to discourage the non-medical or excessive use of prescription drugs.

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.

Health Information Designs, Inc. (HID), administers the Pharmacy Services Lock-In Program. Providers may contact the Pharmacy Services Lock-In Program by calling (800) 225-6998, extension 3045.

Reporting Suspected Member Misuse of Benefits

ForwardHealth operates a therapeutic DUR program designed to routinely monitor prescription drug use by members. The purpose of the DUR program is to identify potential clinical problems related to drug therapy and instances of potentially inappropriate drug use. When a member is identified through the DUR Program of suspected misuse of benefits, the member and the member's primary care provider(s) and pharmacy(s) may be notified.

Providers may also report members suspected of inappropriate prescription drug use by completing the [Pharmacy Services Lock-In Program Request for Review of Member Prescription Drug Use](#) form and submitting the form to the Pharmacy Services Lock-In Program. When a provider refers a member for review, the Lock In Program assesses the member's history of prescription drug claims to identify patterns that suggest possible misuse of prescription drugs.

The Pharmacy Services Lock-In Program monitors claims for pharmacy services and prescription drugs specifically. The Pharmacy Services Lock-In Program does not address other types of member fraud or misuse of benefits, such as misuse of the ForwardHealth identification card or excessive use of emergency room services.

Designated Lock-In Pharmacy and Primary Care Provider

Members enrolled in the Pharmacy Services Lock-In Program are required to designate one Lock-In pharmacy and one Lock-In primary care provider. If the member fails to designate Lock-In providers, ForwardHealth or the member's HMO choose for the member. During the member's enrollment in the Lock-In Program, the member may only receive services from the Lock-In primary care provider and the Lock-In pharmacy unless a referral is in place for another provider.

Fee-for-service members are assigned to one pharmacy and one primary care provider.

Members enrolled in an HMO are assigned to one pharmacy. The HMO is assigned as the member's designated Lock-In primary care provider. The HMO may in turn assign the member to one of the HMO's primary care providers.

Role of the Lock-In Pharmacy and Primary Care Provider

The Lock-In pharmacy fills prescriptions that are medically necessary for the member and works with the Lock-In primary care provider or HMO to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions from prescribers other than the Lock-In primary care provider, but must assure that prescriptions are medically necessary, consistent with the care plan, and are not overlapping with other similar medications. If the member presents a prescription from an emergency room visit, the pharmacist at the Lock-In pharmacy must use his or her professional judgment as to whether or not to fill the prescription.

The Lock-In primary care provider determines what services are medically necessary for the member, provides those services at his or her discretion, and refers the member to other providers if needed. The Lock-In primary care provider also may contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom.

Changing the Designated Lock-In Provider

If circumstances arise that require a change to the member's designated Lock-In pharmacy or primary care provider, contact the Pharmacy Services Lock-In Program at (800) 225-6998, extension 3045. Providers should allow at least one business day for the change to be applied to the member's file.

Referrals for Members Enrolled in the Pharmacy Services Lock-In Program

For all non-emergency, medically necessary, non-pharmacy services, the member's designated Lock-In primary care provider may perform the service or refer the member to another provider, as necessary. The member's Lock-In pharmacy may refer the member to other pharmacies to fill prescriptions if needed.

Referrals to other providers must be on file with the Pharmacy Services Lock-In Program before the member may receive services from any provider other than the designated Lock-In primary care provider or pharmacy. Services provided by providers other than the member's designated Lock-In primary care provider or pharmacy are not reimbursable unless a referral is on file with ForwardHealth.

If the member requires a referral, the Lock-In provider is required to complete the [Pharmacy Services Lock-In Program Member Referral to Another Provider for 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 Services Lock-In Program and the member's HMO.

Note: Emergency medical care is the only exception to the referral requirement.

Looking Up Referral Providers on the ForwardHealth Portal

ForwardHealth Portal member enrollment verification indicates a member's referral providers under the Pharmacy Services Lock-In Program. When a provider looks up member enrollment information, the Portal lists the member's Lock-In pharmacy, Lock-In primary care provider (when applicable), and referral providers.

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.

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.

Special Enrollment Circumstances

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.

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 covers 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 has been granted to the out-of-state provider for provision of a nonemergency service.
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid certified 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 his or her medical services. Border-status providers follow the same policies as Wisconsin providers.

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for BadgerCare Plus services only in cases of acute emergency medical conditions. Providers should use the appropriate ICD-9-CM 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 does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN option. However, babies born to women with incomes over 300 percent of the FPL 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 ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county 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 form](#), for clients to take to the local county 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.

Information for [DOS before January 1, 2009](#), is available.

Out-of-State Youth Program

The OSY program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other members, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide coverage.

OSY providers are subject to the same regulations and policies as other certified border-status providers. For more information about the OSY program, call [Provider Services](#) or write to ForwardHealth at the following address:

ForwardHealth
Out-of-State Youth
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits. Only those individuals who qualify for the [BadgerCare Plus Expansion for Certain Pregnant Women](#) may receive benefits.

"Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. The justice system oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Expansion for Certain Pregnant Women.

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-certified provider for a covered service during the period of retroactive enrollment, according to [DHS 104.01\(11\)](#), Wis. Admin. Code. A Medicaid-certified provider is required to submit claims to Medicaid 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 was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from Medicaid *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 (e.g., 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 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 (if the services provided during the period of retroactive enrollment were covered).

Spendedown 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 "spendedown" 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 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 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.

Prior Authorization

7

Archive Date:09/01/2010

Prior Authorization:Decisions

Approved Requests

PA 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.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA 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 his or her 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.

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, he or she 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 request or amendment request via the Portal to ForwardHealth for processing.

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA decision notices and provider review letters via the secure area of the ForwardHealth Portal. Prior authorization 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.

Denied Requests

When a PA 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 his or her 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](#), [PA/DRF](#), or [PA/HIAS1](#).
- 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](#).

Modified Requests

Modification is a change in the services originally requested on a PA 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 his or her 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.

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 request when authorizing a grant date for the PA.

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.

Returned Requests

A PA 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.

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, photographs, and dental molds will be returned once the PA is finalized for dentists, physicians, and DME providers. 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.

Emergent and Urgent Situations

Emergency Services

In emergency situations, the PA requirement may be waived for services that normally require PA. Emergency services are defined in [DHS 101.03\(52\)](#), Wis. Admin. Code, 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.

Urgent Services

Telephone consultations with DHCAA staff regarding a prospective PA 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 the DHCAA. All telephone consultations for urgent services should be directed to the DHCAA's Bureau of Program Integrity at (608) 266-2521. Providers should have the following information ready when calling:

- Member's name.
- Member identification 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.

Extension of Therapy vs. Spell of Illness

Extension of Therapy Services Encouraged

PT, OT, and SLP providers are encouraged to request an extension of therapy services (instead of SOI) 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.

Extension of Therapy Services Required

PT, OT, and SLP providers are required to request extension of therapy services (instead of SOI) when any of the following are true:

- The onset of the member's condition occurred more than six weeks prior to the request for SOI.
- The combination of the ICD-9-CM code for the PT, OT, or SLP services and the true statement from the Prior Authorization/Spell of Illness Attachment, HCF 11039, does not allow for SOI approval.
- The member's need for PT, OT, or SLP services has exceeded the maximum allowable treatment days for that SOI.
- The member's condition does not qualify for an SOI. (Certain conditions never qualify for an SOI, such as mental retardation.)

Flowchart

To view the flowchart, click on the following link: [Flowchart](#).

Overview

PT, OT, and SLP providers may always choose to request extension of therapy services instead of SOI. 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.

Follow-Up to Decisions

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the ForwardHealth Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request 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 provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Amendments

Providers are required to use the [Prior Authorization Amendment Request](#) to amend an approved or modified PA request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the ForwardHealth Portal as well as by [mail](#) or [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 forms.

Examples of when providers may request an amendment to an approved or modified PA request include the following:

- To temporarily modify a member's frequency of a service when there is a short-term change in his or her medical condition.
- To change the rendering provider information when the billing provider remains the same.
- To change the ForwardHealth Member Identification Number.
- To 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.

Prior Authorization Amendments for Therapy Services

Providers may request an amendment to a current approved or modified PA request to change any of the following:

- The frequency of treatment.
- The grant and expiration date(s).
- The request for cotreatment.
- 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, OT, or SLP 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, submission of a new PA request is required.

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.

The request to amend the PA/RF should include the following:

- 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.

Approval Criteria

ForwardHealth may approve an amendment request if the following are true:

- 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 following:

- 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.

Appeals

If a PA 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. 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](#) letter.

To file an appeal, members may complete and submit a [Request for Fair Hearing](#) 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 his or her 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(s) to submit a claim for the service, each provider should submit the following to ForwardHealth after the service(s) 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
6406 Bridge Rd
Madison WI 53784-0050

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
6406 Bridge Rd
Madison WI 53784-0088

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.

Enddating

Providers are required to use the [Prior Authorization Amendment Request](#) to enddate most PA 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 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.

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 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. After 30 days 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, photographs, and dental models will be returned once the amendment request is finalized for dentists, physicians, and DME providers. 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.

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA requests, regardless of how the PA was initially submitted. If the provider knows the PA number, he or she can enter the number to retrieve the PA information. If the provider does not know the PA number, he or she 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.

Forms and Attachments

An Overview

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

- The [PA/RF](#), [PA/DRF](#), or [PA/HIAS1](#).
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Attachments

In addition to the [PA/RF](#), [PA/HIAS1](#), or [PA/DRF](#), a service-specific PA 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.

PT, OT, and SLP providers have the following choices for PA attachments:

- The [PA/TA](#).
- The [PA/SOIA](#).
- The [PA/B3](#).

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.

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

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA 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
6406 Bridge Rd

Madison WI 53784-0003

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 Prior Authorization Via the Portal

Certain providers may complete the [PA/RF](#) 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.

Prior Authorization Request Form

The [PA/RF](#) is used by ForwardHealth and is mandatory for most providers when requesting PA. 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 claim for prior authorized services.

Prior Authorization Request Form Completion Instructions for Therapy Services

The following sample [PA/RFs](#) for therapy services are available:

- [PT](#).
- [OT](#).
- [SLP](#).

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 ([DHS 104.02\[4\]](#), Wis. Admin. Code).

Under s. [49.45\(4\)](#), Wis. Stats., 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 requests, or processing provider claims for reimbursement. The use of the PA/RF 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](#), and the [PA/B3](#), by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization

Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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 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. Prior authorization and SOI 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 — B-3 for PT
- 161 — B-3 for OT
- 162 — B-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 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.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS to obtain the correct number.

Element 7 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — 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 9 — Name — Member

Enter the member's last name, followed by his or her 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 10 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS — TREATMENT INFORMATION**Element 11 — Diagnosis — Primary Code and Description**

Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — 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 13 — 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 14 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable. If requesting an SOI, leave this element blank.

Element 15 — 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 16 — 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 17 — 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 18 — Procedure Code

Enter the appropriate CPT code, NUBC code, HCPCS code, NDC, or ICD-9-CM surgical code for each service/procedure/item requested. Do not complete this element if requesting a B-3 program service.

Element 19 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required. Enter the "GP" modifier for PT services and the "GO" modifier for OT services. No modifier is needed for SLP services. Do not enter modifiers "TF" or "TL."

Element 20 — POS

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

Element 21 — Description of Service

Enter a written description corresponding to the appropriate CPT code, NUBC code, HCPCS code, NDC, or ICD-9-CM surgical code for each service/procedure/item requested. If requesting a B-3 service, enter "Birth to 3" and the therapy discipline as the description (e.g., "Birth to 3 occupational therapy services" for OT services).

Element 22 — QR

Enter the appropriate quantity (e.g., number of services, days? supply) requested for the procedure code listed. If requesting a therapy SOI, enter "35" in this element.

Element 23 — 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. Do not complete this element if requesting a therapy SOI.

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.

Element 24 — Total Charges

Enter the anticipated total charges for this request. Do not complete this element if requesting a therapy SOI.

Element 25 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Supporting Clinical Documentation

Certain PA 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 photographs will be returned to providers with the finalized PA request. X-rays and photographs must be mailed with the PA request. Mailing dental models with PA requests is recommended.

General Information

An Overview

The PA review process continues to include 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.

Prior Authorization Under the Benchmark Plan, Core Plan and Basic Plan

PA is not required for any therapy services provided under the BadgerCare Plus Benchmark Plan, Core Plan, or Basic Plan. PA requests submitted for Benchmark, Core, or Basic Plan members will be returned to providers without adjudication.

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 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](#):

- [A written report of the recipient's evaluation.](#)
- [An individualized POC if not documented on the PA/TA.](#)
- A copy of the IFSP if the member is a B-3 participant and the services are being requested with the PA/TA. *Refer to [Requesting Services for B-3 Participants](#) for information about submitting the IFSP with the PA/TA.
- A copy of the IEP if the member is a school-age child.*
- A copy of the IPP 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 recipient.

* Only one team member needs to submit the IFSP, IEP, or IPP with a PA request. The team should discuss who will submit the IFSP, IEP, or IPP. The other providers should reference the PA request that was submitted with the IFSP, IEP, or IPP by

indicating the PA number and the date the PA was submitted. The team member designated to submit the IFSP, IEP, or IPP should receive an additional copy from the coordinator. If the member does not have an IFSP, IEP, or IPP, the provider is required to indicate the reason these documents do not exist.

Communication with Members

ForwardHealth recommends that providers inform members that PA 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.

Definition

PA 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.

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA 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 photographs.

Providers who want to designate a separate address for PA correspondence have the following options:

- Update demographic information online via the ForwardHealth Portal. (This option is only available to providers who have established a provider account on the Portal.)
- Submit a [Provider Change of Address or Status](#) form.

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 [DHS 101.03\(96m\)](#), Wis. Admin. Code, are applied when PT, OT, or SLP services are reviewed by ForwardHealth.

DHS 101.03(96m), Wis. Admin. Code, "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 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 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. He has 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, 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, she had been able to ambulate with a walker in her 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 mental retardation, emotional disturbance,

and seizure disorder. His 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 him 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, school, 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/ 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: 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 recipient'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 his or her 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 s. HFS 107.035, is not experimental in nature;

In assessing whether a service is experimental in nature, the Department of Health Services (DHS) 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 the DHFS 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 recipient;

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 she has 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. In this case, the requested therapy is not coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the member. The clinical intent of both services appears to be directed toward achieving the same outcome. Therefore, the PA request would be returned for clarification.

Example 3: A PA request is submitted for SLP services for a six-year-old child diagnosed with developmental delays and dysphagia. All of the child's nutrition is provided by mouth. The diet is modified to ground consistency solids and thickened liquids. The child currently receives SLP services at school and the Individualized Education Plan (IEP) includes facilitation of oral motor exercises supervised by an aide five times per week for 20-30-minute sessions. The school SLP provider re-evaluates the child's oral motor skills monthly. The POC submitted by the community-based provider focuses on oral motor exercises. In this situation, the Medicaid consultant may question if the requested service is duplicative of the services being performed in the school.

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: A 10-year-old child with cerebral palsy has received many years of OT. His current level of functional upper extremity dressing skills includes the ability to push his arm through his sleeve only when the shirt is held over his head and the sleeve is held in place for him. 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 he has 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 his 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 nine-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 his 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.

Flexibility of Approved Services

ForwardHealth allows flexible use of approved, medically necessary PT, OT, and SLP 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 request, a provider and recipient 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 under HFS [107.16](#), [107.17](#), and [107.18](#), Wis. Admin. Code. 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.

Duration of Approved Services

Prior authorization requests for PT, OT, and SLP services must meet the criteria of medically necessary under [DHS 101.03\(96m\)](#), Wis. Admin. Code.

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 Prior Authorization 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.

General Principles for Prior Authorization Requests

A PA 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, OT, or SLP 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 recipient to realistically achieve the treatment goals.
- Medical diagnosis and problem statement (treatment diagnosis) identify the specific treatment needs of the recipient.
- 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 recipient or caregiver and transition responsibility of the PT, OT, or SLP program.

Medical Necessity

ForwardHealth relies on its definition of medically necessary, as stated in [DHS 101.03\(96m\)](#), Wis. Admin. Code, to determine whether a particular service may be reimbursed by Wisconsin Medicaid. Medical necessity for PT, OT, and SLP services is focused on intervention activities that are designed to produce specific outcomes.

ForwardHealth uses the PA 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 recipient'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

Physical therapy, 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.

Prior Authorization Numbers

Upon receipt of the [PA/RF](#), ForwardHealth will assign a PA number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (e.g., 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 diagram and 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; 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP transaction
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.

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA. PA requirements vary for different types of services. Refer to ForwardHealth publications and [DHS 107](#), Wis. Admin. Code, for information regarding services that require PA. According to [DHS 107.02\(3\)\(b\)](#), Wis. Admin. Code, PA is designed to do the following:

- 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 the DHS.

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](#).

Referrals to Out-of-State Providers

PA may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a member attain or regain his or her 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 Wisconsin Medicaid'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 (e.g., 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, non-certified provider, the referring provider should refer the out-of-state provider to the ForwardHealth Portal or [Provider Services](#) to obtain appropriate certification materials, PA forms, and claim instructions.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state non-border-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

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 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 certified by Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider failed to meet 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.

Sources of Information

Providers should verify that they have the most current sources of information regarding PA. 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.

Status Inquiries

Providers may inquire about the status of a PA request through one of the following methods:

- Accessing [WiCall](#), ForwardHealth's AVR system.
- Calling [Provider Services](#).

Providers should have the 10-digit PA number available when making inquiries.

Submission Deadline

PA requests for PT, OT, and SLP services must be received by ForwardHealth within two weeks of performing the initial evaluation. This allows the PA request to be backdated to the date the evaluation was performed.

Grant and Expiration Dates

Backdating

Backdating an initial PA request or SOI to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA or SOI request.
- The request includes clinical justification for beginning the service before PA or SOI was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Expiration Date

The expiration (end) date of an approved or modified PA 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.

Grant Date

The grant (start) date of an approved or modified PA 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.

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA requests (i.e., subsequent PA requests for ongoing services) must be received by ForwardHealth *prior to the expiration date* of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Member Eligibility Changes

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 before the services are provided at each visit.
- When the PA 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.

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA is performed during a member's enrollment period in a state-contracted MCO. 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. 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.

Retroactive Enrollment

If a service(s) that requires PA 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.

Requesting Services That Always Require Prior Authorization

Cotreatment

Cotreatment (interdisciplinary treatment) always requires PA. Cotreatment is simultaneous treatment by two providers of different therapy disciplines during the same time period. Cotreatment may be authorized when the treatment approach is medically necessary to optimize the member's benefit from therapy.

Each of the providers involved in cotreatment 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 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 cotreatment must include the following:

- A specific request for cotreatment.
- Documentation verifying the following:
 - Individual treatment from a single PT, OT, or SLP 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.

When cotreatment is approved, "cotreatment is approved" will be written on the bottom of the PA request.

If cotreatment is approved, two providers of different therapy disciplines can be reimbursed by Wisconsin Medicaid for the same time period. For example, if a member is treated by an OT provider and an SLP provider from 1:00 to 2:00, both providers could receive Medicaid reimbursement for one hour. However, if cotreatment is not approved, both the OT provider and the SLP provider would not receive reimbursement for one hour. Instead, each provider could receive reimbursement for 30 minutes.

Decubitus Ulcers

Treatment of decubitus ulcers using electrical stimulation always requires PA. 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 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 percent 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.

Dual Treatment

Dual treatment (intradisciplinary treatment) always requires PA. 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 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, OT, or SLP provider.

Extension of Therapy

PA is required to extend PT, OT, and SLP services subsequent to the member's initial SOI. As specified in [DHS 107.16\(3\)\(e\)](#), [107.17\(3\)\(e\)](#), and [107.18\(3\)\(e\)](#), Wis. Admin. Code, a PA request to extend therapy services (i.e., 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.

Maintenance Therapy

PA is required for maintenance therapy services. PA requests for maintenance therapy services may be approved when the following apply:

- Specialized knowledge and judgment of a PT, OT, or SLP provider are required to establish and monitor the therapy program.
- The member's functional abilities cannot be maintained without PT, OT, or SLP services.
- Treatment allows the recipient to achieve or maintain a specific level of functional independence.

When evaluating a PA request for maintenance therapy services, ForwardHealth evaluates the member's diagnoses, history, functional status, cognitive abilities, and the chronic or progressive nature of the identified diagnosis impairments or disabilities. In addition, consideration is given to the following:

- Caregivers involved with the recipient.
- Exercises prescribed in the HEP/PMP.
- Level of caregiver assistance required to execute the HEP/PMP.
- Professional skills and expertise the PT, OT, or SLP provider brings to the maintenance program.
- Member's residence (e.g., private residence, group home).
- Specific functional outcomes of the HEP/PMP.
- Treatment goals and anticipated outcomes of the requested services.

Direct Maintenance

ForwardHealth evaluates a PA request for direct maintenance therapy services when one or more of the following conditions are met:

- Nursing personnel cannot handle the member safely and effectively due to the severity or complexity of the member's condition.
- Professional knowledge and judgment of a PT, OT, or SLP provider are required to establish and monitor the therapy maintenance program, including the following:
 - Designing the program as well as monitoring the member's functional abilities.
 - Performing the initial evaluation.
 - Performing any necessary re-evaluations.
 - Providing instruction for nursing personnel, family, caregiver, or recipient.
- The POC and the member's condition require continual adjustment of therapeutic input and/or constant use of therapeutic principles.

Direct maintenance therapy services provided one time per week or less in isolation from an established HEP/PMP are generally not considered effective maintenance of the member's functional abilities. For maintenance therapy services to be effective, the member should also be involved in a routine HEP/PMP.

Routine HEP/PMPs can be performed with the assistance of a caregiver or by the member. Routine HEP/PMPs can influence the recipient's functional abilities on a consistent basis and are considered more effective than PT, OT, or SLP sessions provided one time per week or less.

Monitoring Maintenance

Monitoring maintenance therapy services are most often approved when the professional skills of a PT, OT, or SLP provider are needed to monitor or modify an HEP/PMP that is carried out by the member's caregivers.

In these situations, it is expected that the member's medical condition or functional abilities change often enough to warrant re-evaluation and modification of the HEP/PMP. The frequency requested for maintenance therapy services should be based on the predictability of change in the member's status or condition. Subsequently, an assessment to modify an HEP/PMP needs to be justified in a PA request by a change in the member's medical condition, living situation, adaptive equipment needs, functional abilities, and/or caregiver status.

Approved maintenance therapy services may also involve the process of teaching a routine HEP/PMP to a caregiver to assure follow-through and understanding of the HEP/PMP techniques. The requested frequency should reflect the need for intervention and teaching from a PT, OT, or SLP provider.

Discontinuing Maintenance

When there is an established HEP/PMP and the member's response to treatment is predictable, the following examples of HEP/PMPs may not require the professional skills and expertise of a PT, OT, or SLP provider after the initial treatment and instruction:

- Active-assisted, active, and resisted exercises.
- Activities of daily living.
- Ambulation when level of assistance and/or assistive device has been determined.
- Aquatic exercises.
- Chest PT.
- Cognitive skills - orientation, attention span, problem solving, conceptualization, integration of learning.
- Coping skills.
- Exercises to promote overall fitness.
- Expressive language.
- Fluency (e.g., stuttering).

- Hot/cold treatments.
- Independent living skills.
- Language structure, content, or functions.
- Massage.
- Memory sequencing.
- Play activities that stimulate development/strength/range of motion/coordination.
- Positioning.
- Range of motion exercises.
- Rote, drill activities.
- Sensory integration.
- Standing table.
- Strengthening exercises.
- Stretching exercises.
- Unattended electrical stimulation.
- Voice quality.

The professional skills and expertise of a PT, OT, or SLP provider may be required to execute the member's maintenance therapy services if there is documentation that the nursing personnel or caregivers routinely performed the HEP/PMP as prescribed, but the outcome was affected by one or more of the following:

- Complicating factors related to the member's diagnosis.
- Risk to the member's health or safety as identified by the PT, OT, or SLP provider's reassessment of the HEP/PMP.
- Unforeseeable problems associated with the member's functional abilities being maintained by other caregivers.

In these situations it may be necessary for a period of brief, intensive treatment (if the recipient's status has regressed) prior to resuming a maintenance program. These situations may require a new PA request.

Unlisted Procedures

Services identified by unlisted procedure codes always require PA. Unlisted procedure codes include 97039 for PT services, 97139 for PT and OT services, and 92700 for SLP 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.

Requesting Services for Birth to 3 Participants

Requirements

ForwardHealth requires PT, OT, and SLP providers to submit a PA request only once per child, per therapy discipline, per billing provider for recipients who participate in the B-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 B-3 agency to provide B-3 services. In addition, the B-3 services must be one or both of the following:

- Provided in conjunction with the B-3 initial evaluation and assessment in accordance with HFS 90, Wis. Admin. Code, even if the evaluation and assessment determines the child is not eligible for B-3 services.
- Identified in the member's IFSP 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 in either of the following situations:

- At any time once an evaluation or a PT, OT, or SLP service has been initiated through the B-3 Program.
- Two to four weeks before the child's initial 35 treatment days per discipline have been used.

Situations That Do Not Qualify for Birth to 3

Providers may not use the PA B-3 process for any of the following:

- Children who are not being evaluated as part of an initial B-3 assessment or who are not participating in the B-3 Program. (Some children are not eligible for the B-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 B-3 member.)
- Services provided by ForwardHealth PT, OT, or SLP providers who are not employed by, or under agreement with, a B-3 agency to provide B-3 services.
- Services not identified in the IFSP.
- Procedure codes not listed in the B-3 list as appropriate for [PT](#), [OT](#), or [SLP](#).
- Cotreatment services.

For situations that do not meet the criteria for the PA B-3 process, providers are required to submit the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008, or the Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039. Providers should refer to the Requesting Extension of Therapy, Maintenance Therapy, or Services That Always Require Prior Authorization chapter and the Requesting Spell of Illness chapter of this handbook 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 B-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 HFS 90, Wis. Admin. Code, 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.

Requesting Spell of Illness

Allowable ICD-9-CM Codes for Occupational Therapy (Organized by Codes)

OT providers should use the following chart to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval. Only one of statements "A" through "F" from the PA SOI Attachment, F-11039 must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by ForwardHealth to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

- A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.
- B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.
- C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.
- D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.
- E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.
- F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

- G. 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.

Columns "A" through "F" in the following chart correspond to statements "A" through "F" from Element 11 of the PA/SOIA. The number of days that follow each letter represent the maximum allowable treatment days that correspond with the condition identified in that statement.

The following instructions describe how to use this chart:

- Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
- Follow the row across to determine which statement(s) corresponds with the ICD-9-CM code (Element 11 of the PA/SOIA).
- Follow the appropriate column(s) up to determine the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. OT providers should determine which statement best describes the member's condition.

Only the ICD-9-CM codes listed in the following chart are available for SOI approval. If the ICD-9-CM code for the OT service is not listed, the provider should submit the PA/RF, and the [PA/TA](#).

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 12 Days	B 16 Days	C 18 Days	D 0 Days	E 8 Days	F 11 Days
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0	X				X	

Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436	X				X	
Affective personality disorder, unspecified	301.10					X	
Affective psychoses	296.0-296.9					X	
Anoxic brain damage	348.1	X					X
Anxiety states (incl., panic disorder)	300.00-300.09					X	
Bacterial meningitis	320.0-320.9	X					
Brachial plexus lesions	353.0	X					
Cerebral embolism	434.10-434.11	X					X
Cerebral laceration and contusion	851.0-851.99	X					X
Cerebral thrombosis	434.00-434.01	X					X
Chronic depressive personality disorder	301.12					X	
Contracture of joint	718.4						X
Contracture of palmar fascia (Dupuytren's contracture)	728.6		X				
Diabetes mellitus	250.0-250.93	X					
Disorders of other cranial nerves	352.0-352.9	X					
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9	X					
Encephalopathy, unspecified	348.3	X					X
Epilepsy	345.0-345.91			X			
Explosive personality disorder	301.3					X	
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9	X					
Fracture of lower limb	820-829.1		X				
Fracture of pelvis	808.0-808.9		X				
Fracture of upper limb	810-819.1		X				
Ganglion and cyst of synovium, tendon, and bursa	727.40-727.49		X				
Head injury, unspecified	959.01	X					X
Hemiplegia and hemiparesis	342.0-342.92	X					X
Human immunodeficiency virus (HIV) infection	042			X			X
Huntington's chorea	333.4	X					X
Intracerebral hemorrhage	431	X					X
Intracranial injury of other and unspecified nature	854.0-854.19	X					X
Juvenile chronic polyarthritis	714.30-714.33		X				X
Late effects of acute poliomyelitis	138	X					
Late effects of cerebrovascular disease	438.0-438.9						X
Malignant neoplasm of brain	191.0-191.9	X					
Malignant neoplasm of head, face, and neck	195.0	X					
Meningitis due to other organisms	321.0-321.8	X					
Meningitis of unspecified cause	322.0-322.9	X					
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9	X					
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29	X					X
Multiple sclerosis	340	X					X

Myasthenia gravis	358.0	X				X	
Nontraumatic extradural hemorrhage	432.0	X				X	
Obsessive-compulsive disorders	300.3				X		
Organic personality syndrome	310.1				X		
Osteoarthritis and allied disorders	715.0-715.9		X				
Other and unspecified intracranial hemorrhage following injury	853.0-853.19	X				X	
Other choreas	333.5	X				X	
Other lymphedema	457.1			X		X	
Other nonorganic psychoses	298.0-298.9				X		
Other tenosynovitis of hand and wrist	727.05		X				
Paranoid personality disorder	301.0				X		
Paranoid state (Delusional disorders)	297.0-297.9				X		
Parkinson's disease	332.0-332.1	X				X	
Pathologic fracture	733.10-733.19		X				
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9		X				
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1	X				X	
Postmastectomy lymphedema syndrome	457.0			X		X	
Psychoses with origin specific to childhood	299.0-299.9				X		
Radial styloid tenosynovitis (de Quervain's disease)	727.04		X				
Reflex sympathetic dystrophy	337.20-337.29			X			
Rheumatoid arthritis	714.0		X			X	
Rupture of tendon, nontraumatic (rotator cuff, long head of biceps, hand/wrist extensor/flexor tendons)	727.60-727.64		X				
Schizophrenic disorders	295.0-295.9				X		
Secondary malignant neoplasm of brain and spinal cord	198.3	X					
Secondary malignant neoplasm of other parts of nervous system	198.4	X					
Sickle-cell anemia	282.60-282.69			X		X	
Spinocerebellar disease (ataxias)	334.0-334.9	X				X	
Sprains and strains of joints and adjacent muscles	840-848.9		X				
Subarachnoid hemorrhage	430	X				X	
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59	X				X	
Subdural hemorrhage	432.1	X				X	
Systemic lupus erythematosus	710.0			X			
Systemic sclerosis	710.1			X			
Temporomandibular joint disorders	524.60-524.69			X			
Toxic encephalopathy	349.82	X				X	X
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7		X				
Traumatic amputation of foot (complete) (partial)	896.0-896.3		X				

Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7		X				
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1		X				
Traumatic amputation of thumb (complete) (partial)	885.0-885.1		X				
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1		X				
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9	X					
Trigger finger (acquired)	727.03		X				
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code	A 12 Days	B 16 Days	C 18 Days	D 0 Days	E 8 Days	F 11 Days
Amputation of lower limb	84.10-84.19		X				
Amputation of upper limb	84.00-84.09		X				
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79		X				
Arthroplasty and repair of shoulder and elbow	81.80-81.85		X				
Extracranial ventricular shunt	02.31-02.39	X				X	
Incision of cerebral meninges	01.31	X				X	
Mastectomy	85.41-85.48		X				
Other craniectomy	01.25	X				X	
Other craniotomy	01.24	X				X	
Repair of cerebral meninges	02.11-02.14	X				X	
Revision, removal, and irrigation of ventricular shunt	02.41-02.43	X				X	
Rotator cuff repair	83.63		X				

Allowable ICD-9-CM Codes for Occupational Therapy (Organized by Statements)

OT providers should use the following chart to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval. Only one of statements "A" through "F" from the [PA/SOIA](#) must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by ForwardHealth to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

- A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.
- B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.
- C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.
- D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.
- E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.
- F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

- G. 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.

Each chart is specific to one of the above statements. The statement and the maximum allowable treatment days are provided at the top of each chart.

The following instructions describe how to use these charts:

1. Find the chart that corresponds to the true statement (Element 11 of the PA/SOIA).
2. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
3. If the ICD-9-CM code is listed in the chart, refer to the statement at the top of the chart for the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.
4. If the ICD-9-CM code is not listed in the chart, the combination of the code and statement does not allow for SOI approval. The ICD-9-CM code may be listed under another statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. OT providers should determine which statement best describes the member's condition.

Only the ICD-9-CM codes listed in the following charts are available for SOI approval. If the ICD-9-CM code for the OT service is not listed, the provider should submit the PA/RF and the [PA/TA](#).

Statement A - The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed 12 days for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Bacterial meningitis	320.0-320.9
Brachial plexus lesions	353.0
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Diabetes mellitus	250.0-250.93
Disorders of other cranial nerves	352.0-352.9
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9
Encephalopathy, unspecified	348.3
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9
Head injury, unspecified	959.01
Hemiplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Late effects of acute poliomyelitis	138
Malignant neoplasm of brain	191.0-191.9
Malignant neoplasm of head, face, and neck	195.0
Meningitis due to other organisms	321.0-321.8

Meningitis of unspecified cause	322.0-322.9
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Parkinson's disease	332.0-332.1
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1
Secondary malignant neoplasm of brain and spinal cord	198.3
Secondary malignant neoplasm of other parts of nervous system	198.4
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement B - The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Contracture of palmar fascia (Dupuytren's contracture)	728.6
Fracture of lower limb	820-829.1
Fracture of pelvis	808.0-808.9
Fracture of upper limb	810-819.1
Ganglion and cyst of synovium, tendon, and bursa	727.40-727.49
Juvenile chronic polyarthritis	714.30-714.33
Osteoarthrosis and allied disorders	715.0-715.9
Other tenosynovitis of hand and wrist	727.05
Pathologic fracture	733.10-733.19
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9

Radial styloid tenosynovitis (de Quervain's disease)	727.04
Rheumatoid arthritis	714.0
Rupture of tendon, nontraumatic (rotator cuff, long head of biceps, hand/wrist extensor/flexor tendons)	727.60-727.64
Sprains and strains of joints and adjacent muscles	840-848.9
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7
Traumatic amputation of foot (complete) (partial)	896.0-896.3
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1
Traumatic amputation of thumb (complete) (partial)	885.0-885.1
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1
Trigger finger (acquired)	727.03
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code
Amputation of lower limb	84.10-84.19
Amputation of upper limb	84.00-84.09
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79
Arthroplasty and repair of shoulder and elbow	81.80-81.85
Mastectomy	85.41-85.48
Rotator cuff repair	83.63

Statement C - The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Providers will be allowed **18 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Epilepsy	345.0-345.91
Human immunodeficiency virus (HIV) infection	042
Other lymphedema	457.1
Postmastectomy lymphedema syndrome	457.0
Reflex sympathetic dystrophy	337.20-337.29
Sickle-cell anemia	282.60-282.69
Systemic lupus erythematosus	710.0
Systemic sclerosis	710.1
Temporomandibular joint disorders	524.60-524.69

Statement D - The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. Providers will be allowed **zero days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Affective personality disorder, unspecified	301.10
Affective psychoses	296.0-296.9
Anxiety states (incl., panic disorder)	300.00-300.09
Chronic depressive personality disorder	301.12
Explosive personality disorder	301.3

Obsessive-compulsive disorders	300.3
Organic personality syndrome	310.1
Other nonorganic psychoses	298.0-298.9
Paranoid personality disorder	301.0
Paranoid state (Delusional disorders)	297.0-297.9
Psychoses with origin specific to childhood	299.0-299.9
Schizophrenic disorders	295.0-295.9

Statement E - The member experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **eight days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Encephalopathy, unspecified	348.3
Head injury, unspecified	959.01
Hemiplegia and hemiparesis	342.0-342.92
Human immunodeficiency virus (HIV) infection	042
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Juvenile chronic polyarthritis	714.30-714.33
Late effects of cerebrovascular disease	438.0-438.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Other lymphedema	457.1
Parkinson's disease	332.0-332.1
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1
Postmastectomy lymphedema syndrome	457.0
Rheumatoid arthritis	714.0
Sickle-cell anemia	282.60-282.69
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430

Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement F - The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less. Providers will be allowed **11 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Contracture of joint	718.4
Encephalopathy, unspecified	348.3
Toxic encephalopathy	349.82

Allowable ICD-9-CM Codes for Physical Therapy (Organized by Codes)

PT providers should use the following chart to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval. Only one of statements "A" through "F" from the [PA/SOIA](#) must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by ForwardHealth to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

- A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.
- B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.
- C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.
- D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.
- E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.
- F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

- G. There is a reasonable expectation that the recipient will return to his or her previous level of function by the end of this SOI or sooner.

Note: Statement "D" does not apply to PT services.

Columns "A" through "F" in the following chart correspond to statements "A" through "F" from Element 11 of the PA/SOIA. The number of days that follow each letter represent the maximum allowable treatment days that correspond with the condition identified in that statement.

The following instructions describe how to use this chart:

1. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
2. Follow the row across to determine which statement(s) corresponds with the ICD-9-CM code (Element 11 of the PA/SOIA).
3. Follow the appropriate column(s) up to determine the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. PT providers should determine which statement best describes the member's condition.

Only the ICD-9-CM codes listed in the following chart are available for SOI approval. If the ICD-9-CM code for the PT service is not listed, the provider should submit the PA/RF, and the [PA/TA](#).

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 19 Days	B 11 Days	C 15 Days D N/A*	E 16 Days	F 17 Days	
Abdominal aneurysm, ruptured	441.3			X			
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0	X				X	
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436	X				X	
Ankylosing spondylitis and other inflammatory spondylopathies	720.0-720.9		X				
Anoxic brain damage	348.1	X				X	X
Aortic aneurysm of unspecified site, ruptured	441.5			X			
Arterial embolism and thrombosis of abdominal aorta	444.0			X			
Arterial embolism and thrombosis of thoracic aorta	444.1			X			
Bacterial meningitis	320.0-320.9	X					
Benign paroxysmal positional vertigo	386.11			X			
Brachial neuritis or radiculitis NOS	723.4	X					
Cauda equina syndrome	344.6	X					
Cerebral embolism	434.10-434.11	X				X	
Cerebral laceration and contusion	851.0-851.99	X				X	
Cerebral thrombosis	434.00-434.01	X				X	
Cervicalgia	723.1	X					
Cervicobrachial syndrome (diffuse)	723.3	X					
Complications due to internal joint prosthesis	996.77		X				
Complications due to other internal orthopedic device, implant, and graft	996.78		X				
Complications of reattached extremity or body part	996.91-996.99		X				
Complications of transplanted organ	996.80-996.89			X			
Contracture of joint	718.4						X
Decubitus ulcer	707.0			X			
Diabetes mellitus	250.0-250.93	X					

Disorders of other cranial nerves	352.0-352.9	X					
Dissection of aorta	441.00-441.03			X			
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9	X					
Encephalopathy, unspecified	348.3	X				X	X
Epilepsy	345.0-345.91			X			
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9	X					
Fracture of lower limb	820-829.1		X				
Fracture of pelvis	808.0-808.9		X				
Fracture of upper limb	810-819.1		X				
Gangrene	785.4			X			
Gas gangrene	040.0			X			
Gouty arthropathy	274.0		X				
Head injury, unspecified	959.01	X				X	
Headache	784.0			X			
Hemiplegia and hemiparesis	342.0-342.92	X				X	
Human immunodeficiency virus (HIV) infection	042			X		X	
Huntington's chorea	333.4	X				X	
Infection and inflammatory reaction due to internal joint prosthesis	996.66		X				
Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft	996.67		X				
Internal derangement of knee (incl., Meniscal tears and chondromalacia of patella)	717.0-717.7		X				
Intervertebral disc disorders	722.0-722.93		X				
Intracerebral hemorrhage	431	X				X	
Intracranial injury of other and unspecified nature	854.0-854.19	X				X	
Juvenile chronic polyarthritis	714.30-714.33		X			X	
Kyphoscoliosis and scoliosis	737.30-737.39		X				
Late effects of acute poliomyelitis	138	X					
Late effects of cerebrovascular disease	438.0-438.9					X	
Malignant neoplasm of brain	191.0-191.9	X					
Malignant neoplasm of head, face, and neck	195.0	X					
Mechanical complication of internal orthopedic device, implant, and graft	996.4		X				
Meniere's disease	386.0			X			
Meningitis due to other organisms	321.0-321.8	X					
Meningitis of unspecified cause	322.0-322.9	X					
Migraine	346.0-346.9			X			
Mononeuritis of lower limb and unspecified site	355.0-355.9	X					
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9	X					
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29	X				X	

Multiple sclerosis	340	X				X	
Myasthenia gravis	358.0	X				X	
Nerve root and plexus disorders	353.0-353.9	X					
Nontraumatic extradural hemorrhage	432.0	X				X	
Orthostatic hypotension	458.0			X			
Osteoarthritis and allied disorders	715.0-715.9		X				
Other and unspecified intracranial hemorrhage following injury	853.0-853.19	X				X	
Other choreas	333.5	X				X	
Other disorders of synovium, tendon, and bursa (incl., synovitis and tenosynovitis)	727.0-727.09		X				
Other lymphedema	457.1			X		X	
Other unspecified disorders of back (incl., Lumbago, sciatica, backache)	724.0-724.9		X				
Parkinson's disease	332.0-332.1	X				X	
Pathologic fracture	733.10-733.19		X				
Pathological dislocation of joint	718.2		X				
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9		X				
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1	X					
Postmastectomy lymphedema syndrome	457.0			X		X	
Raynaud's syndrome	443.0			X			
Reflex sympathetic dystrophy	337.20-337.29			X			
Rheumatoid arthritis	714.0		X			X	
Secondary malignant neoplasm of brain and spinal cord	198.3	X					
Secondary malignant neoplasm of other parts of nervous system	198.4	X					
Sickle-cell anemia	282.60-282.69			X		X	
Spasmodic torticollis	333.83		X				
Spinocerebellar disease (ataxias)	334.0-334.9	X				X	
Spondylosis and allied disorders	721.0-721.9		X				
Sprains and strains of joints and adjacent muscles	840-848.9		X				
Subarachnoid hemorrhage	430	X				X	
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59	X				X	
Subdural hemorrhage	432.1	X				X	
Systemic lupus erythematosus	710.0			X			
Systemic sclerosis	710.1			X			
Temporomandibular joint disorders	524.60-524.69		X				
Thoracic aneurysm, ruptured	441.1			X			
Thoracoabdominal aneurysm, ruptured	441.6			X			
Torticollis, unspecified	723.5		X				

Toxic encephalopathy	349.82	X				X	X
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7		X				
Traumatic amputation of foot (complete) (partial)	896.0-896.3		X				
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7		X				
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1		X				
Traumatic amputation of thumb (complete) (partial)	885.0-885.1		X				
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1		X				
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9	X					
Ulcer of lower limbs, except decubitus ulcer	707.10-707.9			X			
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code	A 19 Days	B 11 Days	C 15 Days	D N/A*	E 16 Days	F 17 Days
Amputation of lower limb	84.10-84.19		X				
Amputation of upper limb	84.00-84.09		X				
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79		X				
Arthroplasty and repair of shoulder and elbow	81.80-81.85		X				
Excision of intervertebral disc	80.51		X				
Excision or destruction of intervertebral disc, unspecified	80.50		X				
Extracranial ventricular shunt	02.31-02.39	X				X	
Five-in-one repair of knee	81.42		X				
Incision of cerebral meninges	01.31	X				X	
Intervertebral chemonucleolysis	80.52		X				
Joint replacement of lower extremity	81.51-81.59		X				
Mastectomy	85.41-85.48		X				
Other craniectomy	01.25	X				X	
Other craniotomy	01.24	X				X	
Repair of cerebral meninges	02.11-02.14	X				X	
Revision, removal, and irrigation of ventricular shunt	02.41-02.43	X				X	
Rotator cuff repair	83.63		X				
Spinal fusion	81.00-81.08		X				
Triad knee repair	81.43		X				

* Statement "D" does not apply to PT services.

Allowable ICD-9-CM Codes for Physical Therapy Spell of Illness Approval (Organized by Statements)

PT providers should use the following chart to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval. Only one of statements "A" through "F" from the [PA/SOIA](#) must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by ForwardHealth to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

- A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.
- B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.
- C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.
- D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.
- E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.
- F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

- G. 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.

Note: Statement "D" does not apply to PT services.

Each chart is specific to one of the above statements. The statement and the maximum allowable treatment days are provided at the top of each chart.

The following instructions describe how to use these charts:

1. Find the chart that corresponds to the true statement (Element 11 of the PA/SOIA).
2. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
3. If the ICD-9-CM code is listed in the chart, refer to the statement at the top of the chart for the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.
4. If the ICD-9-CM code is not listed in the chart, the combination of the code and statement does not allow for SOI approval. The ICD-9-CM code may be listed under another statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. PT providers should determine which statement best describes the member's condition.

Only the ICD-9-CM codes listed in the following charts are available for SOI approval. If the ICD-9-CM code for the PT service is not listed, the provider should submit the PA/RF and the [PA/TA](#).

Statement A - The recipient experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed 19 days for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Bacterial meningitis	320.0-320.9
Brachial neuritis or radiculitis NOS	723.4
Cauda equina syndrome	344.6
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Cervicalgia	723.1

Cervicobrachial syndrome (diffuse)	723.3
Diabetes mellitus	250.0-250.93
Disorders of other cranial nerves	352.0-352.9
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9
Encephalopathy, unspecified	348.3
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9
Head injury, unspecified	959.01
Hemiplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Late effects of acute poliomyelitis	138
Malignant neoplasm of brain	191.0-191.9
Malignant neoplasm of head, face, and neck	195.0
Meningitis due to other organisms	321.0-321.8
Meningitis of unspecified cause	322.0-322.9
Mononeuritis of lower limb and unspecified site	355.0-355.9
Mononeuritis of upper limb and mononeuritis multiplex (incl., Carpal tunnel syndrome)	354.0-354.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nerve root and plexus disorders	353.0-353.9
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Parkinson's disease	332.0-332.1
Peroneal muscular atrophy (Charcot-Marie-Tooth disease)	356.1
Secondary malignant neoplasm of brain and spinal cord	198.3
Secondary malignant neoplasm of other parts of nervous system	198.4
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24

Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement B - The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.

Providers will be allowed **11 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Ankylosing spondylitis and other inflammatory spondylopathies	720.0-720.9
Complications due to internal joint prosthesis	996.77
Complications due to other internal orthopedic device, implant, and graft	996.78
Complications of reattached extremity or body part	996.91-996.99
Fracture of lower limb	820-829.1
Fracture of pelvis	808.0-808.9
Fracture of upper limb	810-819.1
Gouty arthropathy	274.0
Infection and inflammatory reaction due to internal joint prosthesis	996.66
Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft	996.67
Internal derangement of knee (incl., Meniscal tears and chondromalacia of patella)	717.0-717.7
Intervertebral disc disorders	722.0-722.93
Juvenile chronic polyarthritis	714.30-714.33
Kyphoscoliosis and scoliosis	737.30-737.39
Mechanical complication of internal orthopedic device, implant, and graft	996.4
Osteoarthritis and allied disorders	715.0-715.9
Other disorders of synovium, tendon, and bursa (incl., synovitis and tenosynovitis)	727.0-727.09
Other unspecified disorders of back (incl., Lumbago, sciatica, backache)	724.0-724.9
Pathologic fracture	733.10-733.19
Pathological dislocation of joint	718.2
Peripheral enthesopathies and allied syndromes (incl., adhesive capsulitis of shoulder, rotator cuff syndrome, epicondylitis, bursitis, tendinitis)	726.0-726.9
Rheumatoid arthritis	714.0
Spasmodic torticollis	333.83
Sprains and strains of joints and adjacent muscles	840-848.9
Temporomandibular joint disorders	524.60-524.69
Torticollis, unspecified	723.5
Traumatic amputation of arm and hand (complete) (partial)	887.0-887.7
Traumatic amputation of foot (complete) (partial)	896.0-896.3
Traumatic amputation of leg(s) (complete) (partial)	897.0-897.7
Traumatic amputation of other finger(s) (complete) (partial)	886.0-886.1
Traumatic amputation of thumb (complete) (partial)	885.0-885.1
Traumatic amputation of toe(s) (complete) (partial)	895.0-895.1

ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code
Amputation of lower limb	84.10-84.19
Amputation of upper limb	84.00-84.09
Arthroplasty and repair of hand, fingers, and wrist	81.71-81.79
Arthroplasty and repair of shoulder and elbow	81.80-81.85
Excision of intervertebral disc	80.51
Excision or destruction of intervertebral disc, unspecified	80.50
Five-in-one repair of knee	81.42
Intervertebral chemonucleolysis	80.52
Joint replacement of lower extremity	81.51-81.59
Mastectomy	85.41-85.48
Rotator cuff repair	83.63
Spinal fusion	81.00-81.08
Triad knee repair	81.43

Statement C - The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Providers will be allowed **15 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Abdominal aneurysm, ruptured	441.3
Aortic aneurysm of unspecified site, ruptured	441.5
Arterial embolism and thrombosis of abdominal aorta	444.0
Arterial embolism and thrombosis of thoracic aorta	444.1
Benign paroxysmal positional vertigo	386.11
Complications of transplanted organ	996.80-996.89
Decubitus ulcer	707.0
Dissection of aorta	441.00-441.03
Epilepsy	345.0-345.91
Gangrene	785.4
Gas gangrene	040.0
Headache	784.0
Human immunodeficiency virus (HIV) infection	042
Meniere's disease	386.0
Migraine	346.0-346.9
Orthostatic hypotension	458.0
Other lymphedema	457.1
Postmastectomy lymphedema syndrome	457.0
Raynaud's syndrome	443.0
Reflex sympathetic dystrophy	337.20-337.29
Sickle-cell anemia	282.60-282.69
Systemic lupus erythematosus	710.0

Systemic sclerosis	710.1
Thoracic aneurysm, ruptured	441.1
Thoracoabdominal aneurysm, ruptured	441.6
Ulcer of lower limbs, except decubitus ulcer	707.10-707.9

Statement D - The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.

This statement does not apply to PT services.

Statement E - The member experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Encephalopathy, unspecified	348.3
Head injury, unspecified	959.01
Hemiplegia and hemiparesis	342.0-342.92
Human immunodeficiency virus (HIV) infection	042
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Juvenile chronic polyarthritis	714.30-714.33
Late effects of cerebrovascular disease	438.0-438.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Other lymphedema	457.1
Parkinson's disease	332.0-332.1
Postmastectomy lymphedema syndrome	457.0
Rheumatoid arthritis	714.0
Sickle-cell anemia	282.60-282.69
Spinocerebellar disease (ataxias)	334.0-334.9
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59

Subdural hemorrhage	432.1
Toxic encephalopathy	349.82
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code
Extracranial ventricular shunt	02.31-02.39
Incision of cerebral meninges	01.31
Other craniectomy	01.25
Other craniotomy	01.24
Repair of cerebral meninges	02.11-02.14
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement F - The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

Providers will be allowed **17 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Anoxic brain damage	348.1
Contracture of joint	718.4
Encephalopathy, unspecified	348.3
Toxic encephalopathy	349.82

Allowable ICD-9-CM Codes for Speech and Language Pathology (Organized by Statements)

SLP providers should use the following chart to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval. Only one of statements "A" through "F" from the [PA/SOIA](#) must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by ForwardHealth to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

- A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.
- B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.
- C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.
- D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.
- E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.
- F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

- G. 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.

Note: Statements "C," "D," and "F" do not apply to SLP services.

Each chart is specific to one of the above statements. The statement and the maximum allowable treatment days are provided at the top of each chart.

The following instructions describe how to use these charts:

1. Find the chart that corresponds to the true statement (Element 11 of the PA/SOIA).
2. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
3. If the ICD-9-CM code is listed in the chart, refer to the statement at the top of the chart for the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.
4. If the ICD-9-CM code is not listed in the chart, the combination of the code and statement does not allow for SOI approval. The ICD-9-CM code may be listed under another statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. SLP providers should determine which statement best describes the member's condition.

Only the ICD-9-CM codes listed in the following charts are available for SOI approval. If the ICD-9-CM code for the SLP service is not listed, the provider should submit the PA/RF and the [PA/TA](#).

Statement A - The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Providers will be allowed 16 days for an SOI with one of the following ICD-9-CM codes.	
Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Abdominal aneurysm, ruptured	441.3
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436
Anoxic brain damage	348.1
Aortic aneurysm of unspecified site, ruptured	441.5
Aphasia	784.3
Arterial embolism and thrombosis of abdominal aorta	444.0
Arterial embolism and thrombosis of thoracic aorta	444.1
Bacterial meningitis	320.0-320.9
Benign neoplasm of lip, oral cavity, and pharynx	210.0-210.9
Cellulitis and perichondritis of larynx	478.71
Cerebral cysts	348.0
Cerebral edema	348.5
Cerebral embolism	434.10-434.11
Cerebral laceration and contusion	851.0-851.99
Cerebral thrombosis	434.00-434.01
Complications of transplanted organ	996.80-996.89
Compression of brain	348.4
Concussion, with prolonged loss of consciousness and return to pre-existing conscious level	850.3
Concussion, with prolonged loss of consciousness without return to pre-existing conscious level	850.4
Cyst of pharynx or nasopharynx	478.26
Diabetes insipidus	253.5
Diabetes mellitus	250.0-250.93

Diffuse diseases of connective tissue	710.0-710.9
Disorders of other cranial nerves	352.0-352.9
Dissection of aorta	441.00-441.03
Edema of larynx	478.6
Edema of pharynx or nasopharynx	478.25
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9
Encephalopathy, unspecified	348.3
Epilepsy	345.0-345.91
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9
Head injury, unspecified	959.01
Hemiplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Intracerebral hemorrhage	431
Intracranial injury of other and unspecified nature	854.0-854.19
Laryngeal spasm	478.75
Malignant neoplasm of brain	191.0-191.9
Malignant neoplasm of head, face, and neck	195.0
Meningitis due to other organisms	321.0-321.8
Meningitis of unspecified cause	322.0-322.9
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29
Multiple sclerosis	340
Myasthenia gravis	358.0
Nontraumatic extradural hemorrhage	432.0
Other and unspecified intracranial hemorrhage following injury	853.0-853.19
Other choreas	333.5
Other disease of larynx (incl., abscess, necrosis, obstruction, pachyderma, and ulcer of larynx)	478.79
Other diseases of pharynx or nasopharynx	478.29
Other diseases of vocal cords (incl., abscess, cellulitis, granuloma)	478.5
Other speech disturbance (incl., dysarthria, dysphasia, slurred speech)	784.5
Paralysis of vocal cords or larynx	478.30-478.34
Parapharyngeal abscess	478.22
Parkinson's disease	332.0-332.1
Polyp of vocal cord or larynx	478.4
Retropharyngeal abscess	478.24
Secondary malignant neoplasm of brain and spinal cord	198.3
Secondary malignant neoplasm of other parts of nervous system	198.4
Spinocerebellar disease (ataxias)	334.0-334.9
Stenosis of larynx	478.74
Subarachnoid hemorrhage	430
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59
Subdural hemorrhage	432.1

Swelling, mass, or lump in head and neck	784.2
Syringomyelia and syringobulbia	336.0
Thoracic aneurysm, ruptured	441.1
Thoracoabdominal aneurysm, ruptured	441.6
Toxic encephalopathy	349.82
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9
Unspecified disease of spinal cord (incl., cord compression)	336.9
Voice disturbance	784.40-784.49
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code
Complete glossectomy	25.3
Correction of cleft palate	27.62
Excision of destruction of lesion or tissue of pharynx	29.31-29.39
Excision of larynx	30.0-30.4
Extracranial ventricular shunt	02.31-02.39
Other craniectomy	01.25
Other craniotomy	01.24
Partial glossectomy	25.2
Pharyngotomy	29.0
Radical glossectomy	25.4
Repair of cleft lip	27.54
Repair of larynx	31.61-31.69
Revision of cleft palate repair	27.63
Revision, removal, and irrigation of ventricular shunt	02.41-02.43

Statement B - The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Providers will be allowed **16 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Benign neoplasm of lip, oral cavity, and pharynx	210.0-210.9

Statement C - The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. **This statement does not apply to SLP services.**

Statement D - The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. **This statement does not apply to SLP services.**

Statement E - The member experienced an exacerbation of a pre-existing condition six weeks ago or less. Providers will be allowed **12 days** for an SOI with one of the following ICD-9-CM codes.

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code
Diffuse diseases of connective tissue	710.0-710.9
Head injury, unspecified	959.01

Hemiplegia and hemiparesis	342.0-342.92
Huntington's chorea	333.4
Late effects of cerebrovascular disease	438.0-438.9
Multiple sclerosis	340
Myasthenia gravis	358.0
Other choreas	333.5
Parkinson's disease	332.0-332.1

Statement F - The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less. **This statement does not apply to SLP services.**

Allowable ICD-9-CM Codes for Speech and Language Pathology Spell of Illness Approval (Organized by Codes)

SLP providers should use the following chart to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval. Only one of statements "A" through "F" from the [PA/SOIA](#) must be true for SOI approval. The combination of the true statement and the primary ICD-9-CM diagnosis code or the ICD-9-CM surgical procedure code is then used by ForwardHealth to assign the maximum allowable treatment days for the SOI. Statement "G" must also be true for SOI approval, but it is not used to determine the maximum allowable treatment days.

The statements below are from Element 11 of the PA/SOIA:

- A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.
- B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.
- C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.
- D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.
- E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.
- F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.

AND

- G. 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.

Note: Statements "C," "D," and "F" do not apply to SLP services.

Columns "A" through "F" in the following chart correspond to statements "A" through "F" from Element 11 of the PA/SOIA. The number of days that follow each letter represent the maximum allowable treatment days that correspond with the condition identified in that statement.

The following instructions describe how to use this chart:

1. Find the appropriate ICD-9-CM code and description. The diagnosis codes are listed before the surgical procedure codes. The code descriptions are organized alphabetically within these categories (Element 10 of the PA/SOIA).
2. Follow the row across to determine which statement(s) corresponds with the ICD-9-CM code (Element 11 of the PA/SOIA).
3. Follow the appropriate column(s) up to determine the maximum allowable treatment days for the corresponding combination of the ICD-9-CM code and statement.

Some ICD-9-CM codes have more than one allowable statement for SOI approval. SLP providers should determine which statement best describes the member's condition.

Only the ICD-9-CM codes listed in the following chart are available for SOI approval. If the ICD-9-CM code for the SLP service is not listed, the provider should submit the PA/RF, and the [PATA](#).

Primary ICD-9-CM Diagnosis Code Description	Primary ICD-9-CM Diagnosis Code	A 16 Days	C N/A *	D N/A *	E 12 Days	F N/A *
Abdominal aneurysm, ruptured	441.3	X				
Acute infective polyneuritis (Guillain-Barre syndrome; postinfectious polyneuritis)	357.0	X				
Acute, but ill-defined, cerebrovascular disease (incl., CVA)	436	X				
Anoxic brain damage	348.1	X				
Aortic aneurysm of unspecified site, ruptured	441.5	X				
Aphasia	784.3	X				
Arterial embolism and thrombosis of abdominal aorta	444.0	X				
Arterial embolism and thrombosis of thoracic aorta	444.1	X				
Bacterial meningitis	320.0-320.9	X				
Benign neoplasm of lip, oral cavity, and pharynx	210.0-210.9	X	X			
Cellulitis and perichondritis of larynx	478.71	X				
Cerebral cysts	348.0	X				
Cerebral edema	348.5	X				
Cerebral embolism	434.10-434.11	X				
Cerebral laceration and contusion	851.0-851.99	X				
Cerebral thrombosis	434.00-434.01	X				
Complications of transplanted organ	996.80-996.89	X				
Compression of brain	348.4	X				
Concussion, with prolonged loss of consciousness and return to pre-existing conscious level	850.3	X				
Concussion, with prolonged loss of consciousness without return to pre-existing conscious level	850.4	X				
Cyst of pharynx or nasopharynx	478.26	X				
Diabetes insipidus	253.5	X				
Diabetes mellitus	250.0-250.93	X				
Diffuse diseases of connective tissue	710.0-710.9	X				X
Disorders of other cranial nerves	352.0-352.9	X				
Dissection of aorta	441.00-441.03	X				
Edema of larynx	478.6	X				
Edema of pharynx or nasopharynx	478.25	X				
Encephalitis, myelitis, and encephalomyelitis	323.0-323.9	X				
Encephalopathy, unspecified	348.3	X				
Epilepsy	345.0-345.91	X				
Facial nerve disorders (incl., Bell's palsy)	351.0-351.9	X				

Head injury, unspecified	959.01	X				X	
Hemiplegia and hemiparesis	342.0-342.92	X				X	
Huntington's chorea	333.4	X				X	
Intracerebral hemorrhage	431	X					
Intracranial injury of other and unspecified nature	854.0-854.19	X					
Laryngeal spasm	478.75	X					
Late effects of cerebrovascular disease	438.0-438.9					X	
Malignant neoplasm of brain	191.0-191.9	X					
Malignant neoplasm of head, face, and neck	195.0	X					
Meningitis due to other organisms	321.0-321.8	X					
Meningitis of unspecified cause	322.0-322.9	X					
Motor neuron disease (incl., Amyotrophic lateral sclerosis)	335.20-335.29	X					
Multiple sclerosis	340	X				X	
Myasthenia gravis	358.0	X				X	
Nontraumatic extradural hemorrhage	432.0	X					
Other and unspecified intracranial hemorrhage following injury	853.0-853.19	X					
Other choreas	333.5	X				X	
Other disease of larynx (incl., abscess, necrosis, obstruction, pachyderma, and ulcer of larynx)	478.79	X					
Other diseases of pharynx or nasopharynx	478.29	X					
Other diseases of vocal cords (incl., abscess, cellulitis, granuloma)	478.5	X					
Other speech disturbance (incl., dysarthria, dysphasia, slurred speech)	784.5	X					
Paralysis of vocal cords or larynx	478.30-478.34	X					
Parapharyngeal abscess	478.22	X					
Parkinson's disease	332.0-332.1	X				X	
Polyp of vocal cord or larynx	478.4	X					
Retropharyngeal abscess	478.24	X					
Secondary malignant neoplasm of brain and spinal cord	198.3	X					
Secondary malignant neoplasm of other parts of nervous system	198.4	X					
Spinocerebellar disease (ataxias)	334.0-334.9	X					
Stenosis of larynx	478.74	X					
Subarachnoid hemorrhage	430	X					
Subarachnoid, subdural, and extradural hemorrhage, following injury	852.0-852.59	X					
Subdural hemorrhage	432.1	X					
Swelling, mass, or lump in head and neck	784.2	X					
Syringomyelia and syringobulbia	336.0	X					
Thoracic aneurysm, ruptured	441.1	X					
Thoracoabdominal aneurysm, ruptured	441.6	X					

Toxic encephalopathy	349.82	X					
Trigeminal nerve disorders (incl., Trigeminal neuralgia)	350.1-350.9	X					
Unspecified disease of spinal cord (incl., cord compression)	336.9	X					
Voice disturbance	784.40-784.49	X					
ICD-9-CM Surgical Procedure Code Description	ICD-9-CM Surgical Procedure Code	A 16 Days	B 16 Days	C N/A *	D N/A *	E 12 Days	F N/A *
Complete glossectomy	25.3	X					
Correction of cleft palate	27.62	X					
Excision of destruction of lesion or tissue of pharynx	29.31-29.39	X					
Excision of larynx	30.0-30.4	X					
Extracranial ventricular shunt	02.31-02.39	X					
Other craniectomy	01.25	X					
Other craniotomy	01.24	X					
Partial glossectomy	25.2	X					
Pharyngotomy	29.0	X					
Radical glossectomy	25.4	X					
Repair of cleft lip	27.54	X					
Repair of larynx	31.61-31.69	X					
Revision of cleft palate repair	27.63	X					
Revision, removal, and irrigation of ventricular shunt	02.41-02.43	X					
* Statements "C," "D," and "F" do not apply to SLP services.							

Backdating

Backdating a SOI request to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the SOI request.
- The request includes clinical justification for beginning the service before the SOI was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Information for [DOS before August 15, 2009](#), is available.

Maximum Allowable Treatment Days

An SOI begins with the first day of evaluation or treatment and ends when the services are no longer required or after the allowable treatment days have been used, whichever comes first. The allowable treatment days include any treatment days covered by other health insurance sources or any treatment days provided by another provider in any setting except for PT, OT, and SLP services provided in schools, which do not count towards the initial SOI under Wisconsin Medicaid and the BadgerCare Plus Standard Plan.

The maximum allowable treatment days that may be granted for each ICD-9-CM code have been determined separately for each therapy discipline. There are two charts for each therapy discipline. Refer to Allowable ICD-9-CM Codes for Physical Therapy (Organized by Codes and Allowable ICD-9-CM Codes for Physical Therapy Spell of Illness Approval (Organized by Statements)

for PT services, Allowable ICD-9-CM Codes for Occupational Therapy (Organized by Codes) and Allowable ICD-9-CM Codes for Occupational Therapy (Organized by Statements) for OT services, and Allowable ICD-9-CM Codes for Speech and Language Pathology Spell of Illness Approval (Organized by Codes) and Allowable ICD-9-CM Codes for Speech and Language Pathology (Organized by Statements) for SLP services. The two charts for each therapy discipline contain the same information, but are organized differently. Appendices 19, 21, and 23 of this handbook are organized alphabetically by the ICD-9-CM code description. Appendices 20, 22, and 24 of this handbook are organized by statements "A" through "F" of the PA/SOIA. Providers should use the appendix that best suits their needs. Instructions for reading each chart are included at the top of the appendix. Providers should use the appendices to determine the allowable combinations of ICD-9-CM codes and statements for SOI approval.

Only the ICD-9-CM codes that are listed in the appendices are available for SOI approval. If the ICD-9-CM code is not listed for the appropriate therapy discipline, the PT, OT, or SLP provider should submit the PA/TA.

Requirements

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 submitting the PA/SOIA, providers are required to provide the appropriate primary ICD-9-CM diagnosis code or the appropriate ICD-9-CM surgical procedure code and answer "yes" or "no" to seven statements about the member's diagnosis or condition. The answers to these statements are used to determine if the SOI request will be approved. If the PA request is approved, ForwardHealth uses the combination of the ICD-9-CM code and the answers to these statements to assign the maximum allowable treatment days for the SOI.

A PA request for an SOI may be approved if all of the following are true:

- The member has incurred a demonstrated functional loss of ability to perform daily living skills within the past six weeks, and there is measurable evidence to support this.
- 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.
- Only one of statements "A" through "F" from Element 11 of the PA/SOIA would be marked "yes." If the member's condition could be categorized by more than one of statements "A" through "F," providers should choose the statement that best describes the reason for the SOI. Examples of situations covered in statements "A" through "F" are provided on the back of the PA/SOIA.

Note:

- Statement "D" does not apply to PT services.
- Statements "C," "D," and "F" do not apply to SLP services.
- If a provider chooses statement "B," they should note that often times precautions are placed on a member's mobility following a fracture or surgical procedure. The SOI, in such cases, can begin the date the precautions are removed and the member demonstrates functional limitations that require the skills of a therapist.

If these conditions are not met, ForwardHealth will return the PA request and instruct the provider to use the PA/TA.

Unused Treatment Days

Unused treatment days 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.

Review Process

Clerical Review

The first step of the PA request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the [PA/RF](#), [PA/HIAS1](#), and [PA/DRF](#) 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 certified.
- 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.

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA 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 [DHS 107.02\(3\)\(e\)](#), Wis. Admin. Code.

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 [DHS 101.03\(96m\)](#), Wis. Admin. Code, "medically necessary" is a service under ch. HFS 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 the DHS.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

Aural Rehabilitation Therapy Following a Cochlear Implant

Providers are required to complete and submit the following forms to ForwardHealth to request PA 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](#).
- [PA/TA](#).

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 recipients 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 Completion Instructions](#). 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 must use CPT procedure code 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) 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 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:

	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

Information for [DOS before August 15, 2009](#), is available.

Overview

ForwardHealth requires PA for the following:

- PT, OT, and SLP services provided subsequent to the member's initial SOI.
- 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 Wisconsin Medicaid and the BadgerCare Plus Standard Plan.

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.

Services That Always Require Prior Authorization

The following PT, OT, and SLP services require PA starting with the first day of treatment:

- Cotreatment.
- Dual treatment.
- HealthCheck "Other Services."
- Services identified by unlisted procedure codes.
- Treatment of decubitus ulcers.
- Treatment for conditions resulting from mental retardation.

Situations Requiring New Requests

Change in Billing Providers

Providers are required to submit a new PA 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 enddating 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.

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA determinations. In the following cases, providers are required to obtain valid, approved PA for those services that require PA:

- A member enrolled in the BadgerCare Plus Standard Plan has a change in income level and becomes eligible for the BadgerCare Plus Benchmark Plan. The member's enrollment status changes to Benchmark Plan.
- A member enrolled in the Benchmark Plan has a change in income level or medical condition and becomes eligible for the Standard Plan or Medicaid. The member's enrollment status changes to Standard Plan or Medicaid accordingly.

Some changes in a member's enrollment status do not affect PA determinations. In the following cases, providers are not required to obtain separate PA because PA will continue to be valid:

- A member enrolled in the Standard Plan becomes eligible for Medicaid coverage. PA granted under the Standard Plan will be valid for Medicaid.
- A member switches from the Standard Plan to the Benchmark Plan and there is already a valid PA on file for the member under the Benchmark Plan.
- A member switches from the Benchmark Plan to the Standard Plan or Medicaid and there is already a valid PA on file for the member under the Standard Plan or Medicaid.

Providers are encouraged to [verify enrollment](#) before every office visit or service rendered. Verifying enrollment will help providers identify changes in member enrollment status and take appropriate actions to obtain PA for services when necessary.

The first time a member switches plans, the provider is required to submit a new PA request, including all required PA forms and attachments. If a member switches back into either of the plans and there is a valid, approved PA on file under that plan, the provider does not need to submit a new PA request.

Providers who have a provider account on the ForwardHealth Portal may use the Portal to check if a valid PA is on file for the

service.

Calculating Limits for Services Requiring Prior Authorization

Any limits that pertain to services requiring PA will accumulate separately under each plan.

Examples

Examples of when a new PA 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 (i.e., BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, 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.

Services Not Performed Before Expiration Date

Generally, a new PA 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.

Submission Options

Fax

Faxing of all PA requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- 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](#) 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 ([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](#). For faxing questions, providers should call (608) 221-4746, extension 80118.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (i.e., 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](#) or the [PA/HIAS1](#) 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) 221-4746, extension 80118, 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 1:00 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, such as the carbon PA/RF, 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.

ForwardHealth Portal Prior Authorization

Providers can use the following PA features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- [Receive](#) decision notice letters and returned provider review letters.
- [Correct](#) returned PA requests and PA amendment requests.
- [Search and view](#) previously submitted PA requests.
- Print a PA cover sheet.

Submitting Prior Authorization 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 requirements, NPI and related data are required on PAs 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 PAs with a status of "Approved" or "Approved with Modifications."

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/JCA](#), and display the form for the provider to complete.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also chose 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](#), must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachments on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachments by mail or fax, they will be matched up with the [PA/RF](#) that was completed on the Portal.

*Please 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 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 the providers.

Additional Supporting Information

Providers may choose to submit additional supporting information via mail or fax. If additional supporting information is needed, 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.

For certain PA process types, providers can choose to upload electronic supporting information through the Portal. Files can be uploaded if the user selects a process type of 117 (Physician services), 124 (Dental services), or 125 (Orthodontic services). Photographs, X-rays and dental models may be uploaded through the Portal if the images are in a JPEG format or created with OrthoCad software (available free on the Web). Dental model OrthoCad files must be uploaded with an extension of ".3dm." JPEG files must be uploaded with an extension of ".jpg" or ".jpeg."

Mail

Any type of PA 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
6406 Bridge Rd
Madison WI 53784-0088

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

STAT-PA

Providers can submit STAT-PA requests for a limited number of services (e.g., certain drugs, selected orthopedic shoes, lead inspections for HealthCheck). The STAT-PA system is an automated system accessed by providers by touch-tone telephone that allows them to receive an immediate decision for certain PA requests.

NPI and related data are required when using the STAT-PA system.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Note: A PA request cannot be submitted through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, or the BadgerCare Plus Basic Plan. PA requests for members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan may be submitted online via the ForwardHealth Portal or on paper.

Reimbursement

8

Archive Date:09/01/2010

Reimbursement:Amounts

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus) may not exceed the BadgerCare Plus-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 BadgerCare Plus-allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the BadgerCare Plus-allowed amount if no additional payment is received from the member or BadgerCare Plus.

Billing Service and Clearinghouse Contracts

According to [DHS 106.03\(5\)\(c\)2](#), Wis. Admin. Code, 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.

Electronic Funds Transfer

EFT 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. Electronic Funds Transfer 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 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 providers during their provisional certification period.

Enrolling in Electronic Funds Transfer

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

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

The following guidelines apply to EFT enrollment:

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

Refer to the ForwardHealth Portal Electronic Funds Transfer User Guide and the Electronic Funds Transfer Fact Page for instructions and more information about EFT enrollment.

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

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

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

Problem Resolution

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

Fee Schedules

[Maximum allowable fee](#) information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT files.

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling [Provider Services](#).

Providers may call Provider Services in the following cases:

- Internet access 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.

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.

[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, OT, and SLP services by referring to outpatient hospital publications.

Natural Environment Enhanced Reimbursement

PT, OT, and SLP providers receive an enhanced reimbursement from BadgerCare Plus when certain PT, OT, and SLP services are provided in the natural environment of a member who participates in the B-3 Program. The enhanced reimbursement applies on a per child, per DOS, per therapy discipline basis. Providers are required to indicate the "TL" modifier when submitting claims for the enhanced reimbursement.

For dates of service prior to November 10, 2008, BadgerCare Plus sends PT, OT, and SLP providers their natural environment enhanced reimbursement as a quarterly lump sum payment. Enhanced reimbursement will be reflected as a cash payout on their remittance information. Detailed information about the cash payout will not appear on remittance information; providers will receive a separate report with detailed information about the cash payout.

For dates of service on and after November 10, 2008, BadgerCare Plus will include the enhanced reimbursement for natural environment in the claim reimbursement for the therapy.

Reimbursement Methods

PT, OT, and SLP 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 percent of the maximum allowable fee.

Collecting Payment From Members

Benchmark Plan Service Limitations

Services that exceed a service limitation established under the BadgerCare Plus Benchmark Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Services with Visit Limitations per Enrollment Year

Under the Benchmark Plan, some services are covered until a member reaches a specified number of visits or days of service per enrollment year. These services include:

- Inpatient hospital stays for substance abuse and mental health treatment.
- Home health visits.
- Nursing home stays.
- Routine eye exams.
- Therapy visits (PT, OT, and SLP).

Note: Hospice services are subject to a lifetime limit under the Benchmark Plan.

Visits and days of service that exceed the service limitations established under the Benchmark Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by BadgerCare Plus. Providers are encouraged to inform the member when he or she has reached a service limitation.

If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers should make payment arrangements with the member in advance.

Services with Dollar Amount Limits per Enrollment Year

Under the Benchmark Plan, some services are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered.

If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the BadgerCare Plus allowed reimbursement, which is the lesser of the provider's usual and customary charges or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's dollar amount service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, the Benchmark Plan reimburses up to \$2,500.00 for DME per member per enrollment year. Suppose a member has expended \$2,200.00 of her DME coverage and requires a new DME item. The BadgerCare Plus-allowed reimbursement for this DME item is \$500.00. BadgerCare Plus will reimburse only \$300.00 before the member has exhausted his or her coverage. The member is responsible for the additional \$200.00. The provider must still accept \$500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than \$200.00.

If a member has already met or exceeded his or her dollar limit, BadgerCare Plus will not reimburse providers for services provided to that member. Providers can bill members up to their usual and customary charges for noncovered services.

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA 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.

Core Plan Service Limitations

Services that exceed a service limitation established under the BadgerCare Plus Core Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Services with Visit Limitations per Enrollment Year

Under the Core Plan, certain services (i.e., PT, OT, and SLP) are covered until a member reaches a specified number of visits or days of service per enrollment year. Visits that exceed the service limitations established under the Core Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by the Core Plan. Providers are encouraged to inform the member when he or she has reached a service limitation. If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers are strongly encouraged to make payment arrangements with the member in advance.

Services with Dollar Amount Limits per Enrollment Year

Under the Core Plan, some services are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered. If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the Core Plan allowed reimbursement, which is the lesser of the provider's usual and customary charges or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's dollar amount service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount paid by BadgerCare Plus. For example, the Core Plan reimburses up to \$2,500.00 for durable medical equipment (DME) per member per enrollment year. Suppose a member has expended \$2,200.00 of his or her DME coverage and requires a new DME item. The allowed reimbursement for this DME item is \$500.00. BadgerCare Plus will reimburse only \$300.00 before the member has exhausted his or her coverage. The member is responsible for the additional \$200.00. The provider must still accept \$500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than \$200.00. If a member has already met or exceeded his or her dollar limit, BadgerCare Plus will not reimburse providers for services provided to that member. Providers can bill members up to their usual and customary charges for noncovered services.

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copayments required by other health insurance sources. Instead, the provider should collect *only* the copayment amount from the member.

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 [copayments](#) for certain services.
- Commercial insurance payments made to the member.
- [Spendedown](#).
- Charges for a [private room](#) in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA 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 certification.

Copayment

Amounts

Standard Plan, Core Plan, and Medicaid

Copayment amounts for PT, OT, and SLP services under the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, 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 copayment amounts.

Medicaid Reimbursement (per procedure code)	Copayment
Up to \$10.00	\$0.50
From \$10.01 to \$25.00	\$1.00
From \$25.01 to \$50.00	\$2.00
Over \$50.00	\$3.00

Benchmark Plan

The copayment amount for PT, OT, and SLP services under the Benchmark Plan is \$15.00 per therapy visit. A therapy visit is defined as all therapy services delivered on the same DOS by the same rendering provider. A single \$15.00 copayment applies regardless of the number or type of procedures administered during the visit.

If a member has two therapy visits with two different providers during a single day, the member is subject to two copayments, one for each visit. However, if a member receives multiple therapy services in the same day from one provider, the member is only subject to one copayment.

Benchmark Plan members residing in a nursing home are subject to copayment for therapy visits.

Basic Plan

The copayment amount for PT, OT, and SLP services under the Basic Plan is \$10.00 per therapy visit. A therapy visit is defined as all therapy services delivered on the same DOS by the same rendering provider. A single \$10.00 copayment applies regardless of the number or types of procedures administered during the visit.

If a member receives therapy services from two different rendering providers during a single day, that counts as two visits and the member is subject to two copayments, one for each visit. However, if a member receives multiple therapy services in the same day from one rendering provider, the member is only subject to one copayment.

There is no copayment maximum limit under the Basic Plan.

Under the Basic Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Exemptions

Wisconsin Medicaid Exemptions

According to [DHS 104.01\(12\)](#), Wis. Admin. Code, providers are prohibited from collecting copayment from the following Wisconsin Medicaid members:

- Members under 18 years of age with incomes at or below 100 percent of the FPL. (For HealthCheck services, members under 19 years old are exempt.)
- Members under 18 years of age who are members of a federally recognized tribe regardless of income.
- Members enrolled in Medicaid because they are in foster care regardless of age.
- Members enrolled in Medicaid through subsidized adoption regardless of age.
- Members enrolled in Medicaid through the Katie Beckett program regardless of age.
- Nursing home residents.
- Members enrolled in Medicaid SSI HMOs or Medicaid special managed care programs receiving managed care-covered services.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

BadgerCare Plus Standard Plan Exemptions

Providers are prohibited from collecting copayment from the following BadgerCare Plus Standard Plan members:

- Members in nursing homes.
- Members under 18 years old who are members of a federally recognized tribe regardless of income.
- Members under 18 years old with incomes at or below 100 percent of the FPL.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.

- Substance abuse day treatment services.
- Surgical assistance.

Wisconsin Well Woman Medicaid Exemptions

Providers are prohibited from collecting copayment from members who have been enrolled into Wisconsin Well Woman Medicaid from the BadgerCare Plus Benchmark Plan or Core Plan for any Medicaid covered service.

Benchmark Plan Exemptions

Certain BadgerCare Plus Benchmark Plan members are exempt from copayment requirements, including the following:

- Members under 18 years old who are members of a federally recognized tribe.
- Pregnant women.

Providers should always use Wisconsin's EVS to verify member enrollment and to [check if the member is subject to a copayment](#).

The following services do not require copayment under the Benchmark Plan:

- Family planning services.
- Preventive services, including HealthCheck screenings.

Limitations

Providers should verify that they are collecting the correct copayment for services as some services have monthly or annual copayment limits. Providers may not collect member copayments in amounts that exceed copayment limits.

Resetting Copayment Limitations

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

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

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

Resetting copayment limitations does not change a member's [Benchmark Plan](#) enrollment year or a member's [Core Plan](#) enrollment year.

Standard Plan and Medicaid

ForwardHealth does not deduct copayment after the first 30 hours or \$1,500.00 of reimbursement for PT, OT, or SLP services per calendar year, per member for members enrolled in the BadgerCare Plus Standard Plan and Medicaid. Copayment limits are calculated separately for each therapy discipline.

The copayment 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 copayment maximum may be reached sooner than an individual provider's records indicate.

When a member has met the copayment maximum, ForwardHealth does not deduct any copayment from the reimbursement to the provider. If the provider collects copayment beyond the copayment maximum, the provider is required to return or credit the member for the extra amount.

Benchmark Plan

There are no monthly or annual copayment limits for therapy services under the BadgerCare Plus Benchmark Plan.

Core Plan

ForwardHealth does not deduct copayment after the first 30 hours or \$1,500.00 of reimbursement for PT, OT, or SLP services per enrollment year, for Core Plan members. Copayment limits are calculated separately for each therapy discipline.

Basic Plan

There are no monthly or annual copayment limits for therapy services under the BadgerCare Plus Basic Plan.

Refund/Collection

If a provider collects a copayment 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 copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus Standard Plan member who fails to make a copayment; however, providers may deny services to a BadgerCare Plus Benchmark Plan member, BadgerCare Plus Core Plan member, or BadgerCare Plus Basic Plan member who fails to make a copayment.

Chapter [49.45\(18\)](#), Wis. Stats., requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Payer of Last Resort

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:

- B-3.
- Crime Victim Compensation Fund.
- GA.
- HCBS waiver programs.
- IDEA.
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP.
 - 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.

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 (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA.
- Other governmental benefits.

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus are the payer of last resort for any covered services. Therefore, the provider is 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.

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.

Reimbursement Not Available

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, OT, or SLP services:

- Group PT.
- 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 inpatients in an institutional program.
- Formal educational services in academic and vocational subjects.
- Foot orthoses or orthopedic or corrective shoes for the following conditions:
 - Flattened arches, regardless of the underlying pathology.
 - Incomplete dislocation or subluxation metatarsalgia with no associated deformities.
 - Arthritis with no associated deformities.
 - Hypoallergenic conditions.
- DME that are not primarily medical in nature, including the following:
 - Air conditioners and air purifiers.
 - Auditory or listening music programs.
 - Baby or infant exercise saucers.
 - Ceiling lifts.
 - Cleaning and disinfectant supplies.
 - Cold air humidifiers.
 - Computers.
 - Copy machines.
 - Dehumidifiers.
 - Educational learning computer programs.
 - Electric page turners.
 - Emergency alert contact systems or services.
 - Exercise and fitness equipment (stationary bicycles, treadmills, pulleys, weights, exercise therapy mats, rowing machines, physioballs, therapy putty, or therapy bands).
 - Extended warranty.
 - Fax machine.
 - Home and environmental modifications (electronic or mechanical devices to control lighting, appliances, etc.).
 - Homemaking equipment (microwaves, food carts, cutting boards, or other adaptive equipment for cooking, cleaning, etc.).
 - Hydrocollator equipment or other devices for heat or cold, including hot and cold packs.
 - Hypoallergenic items including bedding.
 - Intercom monitors.
 - Laptop computers.
 - Lights, horns, flags, or signs for mobility bases.
 - Pacemaker monitors.
 - Playground and recreation equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses, tricycles, or other

- adapted or specialized toys).
- Power door openers.
- Reading machines.
- Restraints.
- Ring walkers.
- Safety equipment (gait belts, harnesses, vests, alarm systems, wanderguard, medical alert bracelets or other types of monitoring equipment, or fences).
- Service animals.
- Telephone modems.
- Telephones, cellular phones, and speaker phones.
- Van or vehicle modifications.
- Video games.
- DME that are not generally accepted by the medical profession as being therapeutically effective. These items include heat and massage foam cushion pads.

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 (e.g., a collection agency) or person who advances money to a provider for the purchase or transfer 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.

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 delivery charges are included in the reimbursement for DME items.

Non-Face-to-Face Time

Only face-to-face time for PT, OT, and SLP 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 B-3 member's natural environment.

Resources

9

Archive Date:09/01/2010

Resources:Contact Information

Member Services

Providers should refer ForwardHealth members with questions to [Member Services](#). The telephone number for Member Services is for member use only.

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, 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.

Field Representative Specialization

The field representatives are assigned to [specific regions](#) of the state. In addition, the field representatives have [specialized](#) in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in [their region who specializes in their provider type](#).

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 certified 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 Portal (information about claims, enrollment verification, and PA 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 ForwardHealth 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 claims submission software.
- Claims processing problems that have not been resolved through other channels (e.g., telephone or written correspondence).
- Referrals by a Provider Services telephone correspondent.
- Complex issues that require extensive explanation.

Field representatives primarily 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 at (800) 362-3002.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI,

is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN.

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

- Name or alternate contact.
- County and city where services are provided.
- Name of facility or provider whom they are representing.
- NPI or provider number.
- Telephone 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:

- Member's name.
- Member identification number.
- Claim number.
- DOS.

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, and WWWP 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 submissions.
- Certification.
- COB (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.
- PA 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 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 member identification number.
- Claim number.

- PA number.
- DOS.
- Amount billed.
- RA.
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- WCDP and WWWP (for inquiries from all providers regarding WCDP or WWWP).
- Dental (for all inquiries regarding dental services).
- Medicaid or SeniorCare Pharmacy (for pharmacy providers) or STAT-PA for STAT-PA inquiries, including inquiries from pharmacies, DME providers for orthopedic shoes, and HealthCheck providers for environmental lead inspections.
- Medicaid and BadgerCare Plus institutional services (for inquiries from providers who provide hospital, nursing home, home health, personal care, ESRD, and hospice services or NIP).
- Medicaid and BadgerCare Plus professional services (for inquiries from all other providers not mentioned in the previous menu prompts).

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

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](#) 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
 6406 Bridge Rd
 Madison WI 53784-0005

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.

Provider Suggestions

The DHCAA is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the [Provider Suggestion](#) form.

Resources Reference Guide

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

Electronic Data Interchange

Companion Documents

Purpose of Companion Documents

ForwardHealth [companion documents](#) provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion documents applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP. Companion documents are intended for information technology and systems staff who code billing systems or software.

The companion documents complement the federal HIPAA 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 (e.g., exchange interfaces, transaction administration, and data preparation).
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA, and enrollment inquiries).

Companion documents do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion documents cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation).
- Transaction administration (e.g., tracking claims submissions, contacting the [EDI Helpdesk](#)).
- Transaction formats.

Revisions to Companion Documents

Companion documents may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion document on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for the revised companion documents on the Portal. If trading partners do not follow the revisions identified in the companion document, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the front of the revised companion document lists the changes that have been made. The date on the companion document reflects the last date the companion document was revised. In addition, the version number located in the footer of the first page is changed with each revision.

Data Exchange Methods

The following data exchange methods are supported by the [EDI Department](#):

- 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 5.1, 270/271, or 276/277 transactions via an approved clearinghouse.

The EDI Department supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call [Provider Services](#).

Electronic Transactions

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 Department, trading partners may exchange the following electronic transactions:

- 270/271. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277. The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 835. The electronic transaction for receiving remittance information.
- 837. The electronic transaction for submitting claims and adjustment requests.
- 997. The electronic transaction for reporting whether a transaction is accepted or rejected.
- TAI Interchange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interchange level errors.
- NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS electronic transaction for submitting pharmacy claims.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837 transactions and download the 997 and the 835 transactions. To obtain PES software, providers may download it from the ForwardHealth Portal or may request it from the [EDI Helpdesk](#).

Trading Partner Profile

A [TPP](#) 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 TPP.

To determine whether a TPP 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 software, are required to complete the TPP.

- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a TPP.
- 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 TPP.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the [EDI Helpdesk](#).

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

270/271 Transactions

The [270/271](#) 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, 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 certification 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 certification on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

An Overview

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

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

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 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 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.

Copayment Information

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

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

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

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

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 to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- [WiCall](#), Wisconsin's AVR system.
- Commercial enrollment verification vendors.
- 270/271 transactions.
- [Provider Services](#).

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Enrollment Verification on the Portal

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

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

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

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

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

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

Entering Dates of Service

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

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

- The "From" DOS 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.

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS to verify enrollment, otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN 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.

Member Identification Card Does Not Guarantee Enrollment

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

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

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

Forms

An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

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® Web site. 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® Web site](#) 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.

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
6406 Bridge Rd
Madison WI 53784-0003

Portal

Claims and Adjustments Using the ForwardHealth Portal

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

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

Conducting Recertification Via the ForwardHealth Portal

Providers can conduct [recertification](#) online via a secure recertification area of the ForwardHealth Portal.

Cost Share Reports for Long-Term Managed Care Organizations

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

Creating a Provider Account

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

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

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

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

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

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

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

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

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

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

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

Electronic Communications

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

Enrollment Verification

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

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

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.
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits [online](#).

ForwardHealth Portal Helpdesk

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

Inquiries to ForwardHealth Via the Portal

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

Internet Connection Speed

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

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

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

Logging in to the Provider Area of the Portal

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

Managed Care Organization Portal

Information and Functions Through the Portal

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

The following information is available through the Portal:

- Certified Provider Listing of all Medicaid-certified providers.
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long term care MCOs.
- Electronic messages.

- Enrollment verification by entering a member ID or SSN with date of birth and a "from DOS" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, and taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

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.

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN. The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for recertification on the Portal. Providers will receive a separate PIN for recertification.

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

Providers may request a PIN by following these steps:

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

The financial payer is one of the following:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
 - SSI.
 - WCDP.
 - The WWWP.
- c. Click **Submit**.
 - d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

Revisions to policy information are incorporated immediately after policy changes have been issued in *ForwardHealth Updates*. The Online Handbook also links to the [ForwardHealth Publications page](#), an archive section that providers can use to research past policy and procedure information.

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections and chapters. Sections within each handbook may include the following:

- Certification.
- Claims.
- Coordination of Benefits.

- Managed Care.
- Member Information.
- Prior Authorization.
- Reimbursement.
- Resources.

Each section consists of separate chapters (e.g, claims submission, procedure codes), which contain further detailed information.

Advanced Search Function

The Online Handbook has an advanced search function, which allows providers to search for a specific word or phrase within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the advanced search function by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Complete the two drop-down selections at the right to narrow the search by program and service area, if applicable. This is not needed if providers wish to search the entire Online Handbook.
4. Click "Advanced Search" to open the advanced search options.
5. Enter the word or phrase you would like to search.
6. Select "Search within the options selected above" or "Search all handbooks, programs and service areas."
7. Click the "Search" button.

ForwardHealth Publications Archive Area

The ForwardHealth Publications page of the Online Handbook allows providers to view old *Updates* and 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 "Online Handbooks" link in the upper left "Providers" box.
3. Click on the "Updates and Handbooks" link. (This link is below the three drop-down menus.)

Other Business Enhancements Available on the Portal

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

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

Portal Account Administrators

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

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

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO.
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA. As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

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

Establish an Administrator Account

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

Portal Clerk Administrators

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

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

Portal Clerks

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

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

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can [submit PAs](#) 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 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.

Public Area of the Provider Portal

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

Maximum Allowable Fee Schedules

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

Online Handbook

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

Revisions to information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research past policy changes.

ForwardHealth Publications Archive Section

The [ForwardHealth Publications page](#), available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the [Portal Training page](#), which contains an up-to-date calendar of all available training. Additionally, providers can view [Webcasts](#) of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Certification

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

Other Business Enhancements Available on the Portal

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

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

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

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

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

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Electronic Communications

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

Enrollment Verification

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

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

Using the Portal to check enrollment may be more efficient than calling the AVR system or the EVS (although both 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.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT.
- Track provider-submitted PA requests.

System and Browser Requirements

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

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Trading Partner Portal

The following information is available on the public [Trading Partner](#) area of the Portal:

- Trading partner [testing packets](#).
- [Trading Partner Profile](#) submission.
- [PES](#) software and upgrade information.
- EDI [companion documents](#).

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

Updates

Full-Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling [Provider Services](#).

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is distributed on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account will be notified through their Portal mailbox when the *Update Summary* is available on the Portal. Providers without a Portal account will receive a paper copy of the *Update Summary* unless they have opted out of receiving paper publications.

Providers may obtain copies of *Updates* listed in the *Update Summary* from the Portal. A Web address that directly links providers to a list of each month's *Updates* is listed in the *Update Summary*. Providers may then print specific articles to keep on paper as well as navigate to other Medicaid information available on the Portal.

Providers without Internet access may call [Provider Services](#) to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Revisions to policy information are incorporated into the Online Handbook immediately after policy changes have been issued in *Updates*. The Online Handbook also includes a link to the [ForwardHealth Publications page](#), an archive section where providers can research past changes.

Multiple Ways to Access ForwardHealth Publications

Providers may choose to receive notification on paper via U.S. mail or through a new e-mail subscription service. Providers who have established a ForwardHealth Portal account will automatically receive notification of *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary* in their Portal message box. Providers will receive notification via their Portal accounts or e-mail subscription much sooner than on paper. Certain providers may choose not to receive *Updates* and the monthly *Update Summary*.

ForwardHealth Portal Account

Providers who establish a Portal account will not receive the *Update Summary* on paper through the U.S. mail. Providers are still bound to the program's rules, policies, and regulations even if they do not receive the *Update Summary* through the mail.

Mail

ForwardHealth will mail the monthly *Update Summary* to providers who do not have a Portal account.

E-mail Subscription Service

Providers and other interested parties may sign up on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or WCDP) and provider type (e.g., physician, hospital, DME vendor), and which publication notifications they would like to receive. Any number of staff or other interested parties from an

organization may sign up for an e-mail subscription. Providers who sign up for an e-mail subscription will continue to receive paper copies of the monthly *Update Summary* unless they have a Portal account or have opted out of receiving paper publications.

Users may sign up for an e-mail subscription by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Subscribe to Provider Notifications" link from the Quick Links box on the right side of the screen.
4. Register by supplying e-mail address.

Users may register for additional electronic subscriptions by adding service areas listed under "Available Subscriptions" on the right side of the subscriptions page.

WiCall

Enrollment Inquiries

WiCall is an [AVR](#) system that allows providers with touch-tone telephones direct access to enrollment information. A [WiCall Quick Reference Guide for Enrollment Inquiries](#) is available.

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 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 on the DOS or within the DOS range selected, HPSA information will be given.
- MCO: 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 number, if available, that exists on the DOS or within the DOS range selected will be listed.
- Other Commercial 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.
 - To request enrollment information for the same member using a different financial payer.
 - To hear another member's enrollment information using the same financial payer.
 - To hear another member's enrollment information using a different financial payer.
 - To 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.

Entering Letters into WiCall

For some WiCall inquiries, health care providers are required to enter their taxonomy code with their NPI. Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Information Available Via WiCall

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

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

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

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

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

Claim Status

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

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

Enrollment Verification

Providers may request enrollment status 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. Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

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

Prior Authorization Status

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

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.

Quick Reference Guide

The WiCall [AVR Quick Reference Guide](#) displays the information available for WiCall inquiries.