Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

Topic #196

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 (prior authorization) 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.

Topic #899

CLIA Certification or Waiver

Congress implemented CLIA (Clinical Laboratory Improvement Amendment) to improve the quality and safety of laboratory services. CLIA requires *all* laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This requirement applies even if only a single test is being performed.

CLIA Enrollment

The federal CMS (Centers for Medicare and Medicaid Services) 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 CLIA-monitored 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. There are five types of CLIA certificates as defined by CMS:

1. *Certificate of Waiver*. This certificate is issued to a laboratory to perform only waived tests. The CMS Web site identifies the most current list of waived procedures. BadgerCare Plus identifies allowable waived procedures in maximum allowable fee schedules.
2. *Certificate for Provider-Performed Microscopy Procedures (PPMP)*. This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests. 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. *Certificate of Registration*. This certificate is issued to a laboratory and enables the entity to conduct moderate- or high-complexity laboratory testing, or both, until the entity is determined by survey to be in compliance with CLIA regulations.
4. *Certificate of Compliance*. This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
5. *Certificate of Accreditation*. This is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. The six major approved accreditation organizations are:
    - JCAHO (Joint Commission on Accreditation of Healthcare Organizations).
    - CAP (College of American Pathologists).
    - COLA.

- American Osteopathic Association.
- American Association of Blood Banks.
- ASHI (American Society of Histocompatibility and Immunogenetics).

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 Provider Maintenance in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify Provider Maintenance of changes in CLIA certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Following is the address for providing written notification to Provider Maintenance:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

If a provider has a new certificate type to add to its certification information on file with ForwardHealth, the provider should send a copy of the new certificate to the above address. When a provider sends ForwardHealth a copy of a new CLIA certificate, the effective date on the certificate will become the effective date for CLIA certification on file with ForwardHealth.

Topic #3969

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 (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual providers within the group.

Group billing providers may not have more than one group certified by Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program) with the same ZIP+4 address, NPI (National Provider Identifier), and taxonomy code combination. Providers at the same ZIP+4 address are required to differentiate their certification using an NPI or taxonomy code that uniquely identifies their 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., 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.

Topic #467

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 (Terms of Reimbursement).
- Provider application.
- Provider Agreement and Acknowledgement of Terms of Participation.
- Other forms related to certification.

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

General Certification Information

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

Certification Requirements

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

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

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

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

Terms of Reimbursement

Wisconsin Medicaid certification materials include Wisconsin Medicaid's 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 (Department of Health Services). 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.

Topic #190

Completing Certification Applications

Health care providers are required to include their NPI (National Provider Identifier) 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 (application tracking number) 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.

Topic #2840

Dental Hygienists

Dental hygienists may be separately certified by Wisconsin Medicaid, according to DHS 105.01(5m) and 105.06(2), Wis. Admin. Code.

Note: Medicaid certification for dental hygienists is optional. Dental hygienists who operate under a Medicaid-certified dentist's written or oral prescription may continue to provide services under that dentist's Medicaid billing provider number, as they currently do, without becoming individually certified.

Certification Requirements

Dental hygienists must be licensed by the DR&L (Department of Regulation and Licensing) and operate within their scope of practice as defined by DR&L regulations. To be separately certified by Wisconsin Medicaid, dental hygienists are required to meet *all* of the following requirements:

- Be licensed to practice dental hygiene pursuant to s. 447.04(2), Wis. Stats.
- Operate within the scope of dental hygiene as defined under s. 447.01(3) and s. 447.06, Wis. Stats.

Individual providers within dental services groups are required to be Medicaid certified (except for dental hygienists) because they are required to identify the performing provider number of the individual provider who performed the service on claims.

Dental hygienists who would like to obtain Medicaid certification may complete the Dental Certification Packet that includes the Declaration of Active Practice Experience (F-11165) form.

Within the Dental Certification Packet, providers should indicate "dental hygienist" on page 4 of the Provider Application, HCF-11003 (Rev. 07/04), for the specialty under "Dentist."

Providers without Internet access may request a certification packet(s) by doing one of the following:

- Contacting Provider Services.
- Sending a request in writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Practice Settings

For a dental hygienist employed or contracted by a public health entity, the presence, authorization, or prescription of a dentist is *not* required to provide dental hygiene or perform remediable procedures (i.e., prophylaxis, topical application of fluoride, and sealants). Public health entities are described in ss. 447.06(2)(a)2, 447.06(2)(a)3, or 447.06(2)(a)5, Wis. Stats. as:

- A school board of a public school or a governing body of a private school.
- A school for the education of dentists or dental hygienists.
- A local health department, as defined in s. 250.01(4), Wis. Stats.

Sections 447.06(2)(b) and 447.06(2)(c), Wis. Stats. specify requirements for when a dentist's presence, authorization, or prescription is required for a hygienist employed or contracted with any other entity. Other entities include the following:

- Dental offices.
- Facilities (e.g., a hospital or hospice).
- Charitable institutions.
- Non-profit home health care agencies.
- Non-profit dental care programs serving primarily indigent, economically disadvantaged, or migrant worker populations.

Providers are reminded that dental hygienists operating in any setting who meet the certification criteria are eligible for Medicaid certification.

Medicaid Requirements for Dental Hygienists Employed or Contracted by a Public Health Entity

Medicaid-certified dental hygienists employed or contracted by one of the previously listed public health entities are required to maintain additional documentation when providing sealants to receive Medicaid reimbursement.

Documentation Requirements

In addition to following documentation requirements for all Medicaid-certified providers, dental hygienists *and* the public health entities for which they work are required to maintain written documentation of all the following:

- The relationship between the dental hygienist and the public health entity.
- Any referral of a member who has a condition that cannot be treated within the dental hygienist's scope of practice to any entity that is under the supervision of a licensed dentist (e.g., private dental practice or a federally qualified health center that provides dental services).
- Any consultations made with a licensed dentist.
- Notifications made to the contract agency, as stated previously.

Topic #2839

Dentists

To be eligible for Wisconsin Medicaid certification, dentists practicing in the state of Wisconsin are required to maintain an active license with the state Dental Examining Board according to section 447.05, Wis. Stats. Dentists practicing outside the state of Wisconsin who provide services to BadgerCare Plus members must be licensed by the Dental Examining Board in their own state.

During the certification process, Wisconsin Medicaid asks dental providers to identify one of the following practice specialties:

- Endodontics.
- General practice.
- Oral pathology.
- Oral surgery.
- Orthodontics.
- Pediatric dentistry.
- Periodontics.
- Prosthodontics.

Oral Surgery Billing

Dental providers who choose the oral surgery or oral pathology specialty use the American Medical Association's CPT (Current Procedural Terminology) procedure codes for billing most oral surgeries. Dental providers with all other specialties use the ADA (American Dental Association) CDT (Current Dental Terminology) procedure codes for billing most oral surgeries. Dentists who want different oral surgery billing than assigned to their specialty must complete a form requesting a change.

M.D./D.D.S.

When a provider is licensed as both a D.D.S. and M.D., Wisconsin Medicaid encourages the provider to be certified as a dentist with an oral surgery specialty.

Topic #191

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.

Topic #193

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 *ForwardHealth Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List (F-11015 (10/08)) 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.

Topic #3410

Multiple Locations

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

Topic #654

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 (National Provider Identifier) 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.

Topic #4449

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 and assigned provider type and specialty. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare.

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

Topic #1619

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 (prior authorization) 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 (F-11001 (10/08)). 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.

Topic #4457

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 (prior authorization) 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 (F-1181 (10/08)) 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 (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) 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.

Topic #1931

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.

Topic #1932

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 (F-1181 (10/08)) 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.

Topic #4448

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 (application tracking number) 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.

Topic #2838

Urgent Care Form for Noncertified In-State Dental Providers

Wisconsin Medicaid reimburses noncertified in-state dental providers for providing urgent dental services to a BadgerCare Plus members or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation 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 dental providers must be submitted with an Urgent Care Dental In-State Emergency Provider Data Sheet (F-11013 (02/09)). The Urgent Care Dental In-State Emergency Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

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

Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

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

Topic #1640

Availability of Records to Authorized Personnel

The DHCAA (Division of Health Care Access and Accountability) 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 (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized 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 (managed care organizations), including HMOs (Health Maintenance Organizations) and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS (Department of Health Services).

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

Topic #200

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 (Health Insurance Portability and Accountability Act of 1996)) 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.

Topic #201

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.

Topic #202

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.

Topic #199

Member Access to Records

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

Fees for Health Care Records

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

Per 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.

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

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

For information regarding fees that may be charged to members for copies of health care records, refer to s. 146.83(3f), Wis. Stats.

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to 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.

Topic #204

Record Retention

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

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by ForwardHealth 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 ForwardHealth.

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of 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 copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

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

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

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

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

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

Request for a Statement from a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) 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.

Topic #1646

Release of Billing Information to Government Agencies

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

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

Ongoing Responsibilities

Topic #220

Accommodating Members with Disabilities

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

Topic #215

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 (Division of Quality Assurance) certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD (end-stage renal disease) services providers.
- FQHCs (federally qualified health centers).
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs (rural health clinics).

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 (Department of Health Services) 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.

Topic #219

Civil Rights Compliance (Nondiscrimination)

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

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

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

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

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access.
- Not providing translation of vital documents to the LEP groups who represent 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 (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements.

Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

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

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

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

Title VI of the Civil Rights Act of 1964

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

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

Title VII of the Civil Rights Act of 1964

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

Federal Rehabilitation Act of 1973, Section 504

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

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

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

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods

that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA (Americans with Disabilities Act) 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.

Topic #198

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.

Topic #216

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 (prior authorization) for services, when required.
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to 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.

Topic #217

Keeping Information Current

Types of Changes

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

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial.
- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI (National Provider Identifier).
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.
- Taxonomy code.
- Telephone number, including area code.

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

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments 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 (F-01181 (09/11)) 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 (Division of Quality Assurance) 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.

Topic #577

Legal Framework

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

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - Regulation — Title 42 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 (Department of Health Services). Within the DHS, the DHCAA (Division of Health Care Access and Accountability) is directly responsible for managing these programs.

Topic #2837

Section 447.02, Wis. Stats., and DHS 107.07, Wis. Admin. Code provide the legal framework for dental services.

Topic #2836

Reducing the Number of Missed Appointments

The following suggestions will reduce missed appointments for all patients, including BadgerCare Plus members. When scheduling appointments, providers should explain to members the importance of keeping appointments and the office rules regarding missed appointments. ForwardHealth offers the following suggestions to decrease the "no show" rate:

- Contact the member by telephone or postcard prior to the appointment and remind the member of the time and place of the appointment and the importance of canceling scheduled appointments in advance.
- Require members to verify their appointment by calling the dental office, using the following procedures:
  1. Explain the policy carefully to your members when they make appointments.
  2. Send postcards to remind members of their appointments, of the office policy regarding confirming their appointments, and of the need to call immediately to confirm the upcoming appointment.
  3. If they do not call by a given day before their appointment, give the appointment to another patient.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage staff from those programs to ensure that scheduled appointments are kept.
- Call the local city/county health department or the HealthCheck Hotline at (800) 722-2295 for information about HealthCheck services in your area. Individual dentists may agree only to accept referrals from HealthCheck providers, such as the local public health agencies and physicians. Some health departments have outreach staff who may be able to assist members in getting to their dental appointments.
- Contact programs and agencies, such as HeadStart, sheltered workshops, or human service departments, to develop a referral system. Some of these agencies may assist members in finding transportation and keeping dental appointments.
- If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call LogistiCare for NEMT (non-emergency medical transportation). Most Medicaid and BadgerCare Plus members may receive NEMT services through LogistiCare.

Prescription

Topic #525

General Requirements

It is vital that prescribers provide adequate supporting clinical documentation for a pharmacy or other dispensing providers to fill a prescription. Except as otherwise provided in federal or state law, a prescription must be in writing or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed.
- The service required, if applicable.
- The date of issue of the prescription.
- The prescriber's name and address.
- The member's name and address.
- The prescriber's signature (if the prescriber writes the prescription) and date signed.
- The directions for use of the prescribed drug, item, or service.

Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the DEA (Drug Enforcement Agency) number of the prescriber on all prescriptions. DEA numbers are not required on claims or PAs (prior authorizations).

Members in Hospitals and Nursing Homes

For hospital and nursing home members, prescriptions must be entered into the medical and nursing charts and must include the previously listed information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills that are valid for shorter periods of time.

Topic #2835

Dentists

Within their scope of practice, dentists may prescribe drugs for BadgerCare Plus members. Before administering or prescribing any Schedule II, III, IV, or V pharmaceutical agents, the provider must also obtain a DEA (Drug Enforcement Administration) certification of registration. Wisconsin Medicaid does not reimburse providers for any charges associated with writing the prescription or for take-home drugs dispensed by a dentist.

Topic #11117

Opioid Monthly Prescription Fill Limit

Opioid drugs are limited to five prescription fills per calendar month for BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare members.

These limits do not affect members who are in a nursing home or hospice care.

The following drugs will be exempt from the opioid monthly prescription fill limit:

- Suboxone film and tablet.
- Buprenorphine tablet.
- Methadone solution.
- Opioid antitussive liquid.

Prescriber Responsibilities

If a member enrolled in the Standard Plan, Medicaid, and SeniorCare require more than five opioid prescription fills in a month, the prescriber may request a policy override through the DAPO (Drug Authorization and Policy Override) Center. An override is required for each opioid fill that exceeds the five prescription fill limit per calendar month.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid monthly prescription fill limit.

When calling the DAPO Center to request a policy override for opioids, the following information must be provided:

- Prescriber's name and NPI (National Provider Identifier).
- Member's name and ID.
- Pharmacy's name and telephone number where the member attempted to have the prescription filled.
- Date the prescription was attempted to be filled.
- Drug name, strength, and quantity.
- Instructions for use.

The DAPO Center will provide information to the prescriber regarding the member's recent medication history.

If the prescriber determines an override is medically necessary, the DAPO Center will record the override, and the prescriber should contact the member and the pharmacy. When contacting the member, the prescriber should use this opportunity to discuss the appropriate use of opioids.

If the prescriber decides that it is not medically necessary to override the opioid monthly prescription fill limit, the prescriber should contact the member and discuss follow-up care. If the override is not given, the prescriber should contact the pharmacy to have the prescription canceled.

Pharmacy Responsibilities

When pharmacies are contacted by a prescriber and notified that an override is available, the pharmacy should submit the claim for the opioid. Pharmacies are responsible for submitting claims for opioids within three days of the override being obtained by the prescriber. If the pharmacy provider does not submit the claim within the three day time period, the claim will be denied.

Note: If the pharmacy provider contacts the DAPO Center to obtain an override, the DAPO Center will inform the pharmacy provider that the prescriber is responsible for obtaining the override.

If a prescriber does not override the opioid monthly prescription fill limit for members enrolled in the Standard Plan, Medicaid, or SeniorCare, the service is considered noncovered.

If a pharmacy has difficulty with claim submission related to the opioid monthly prescription limit, contact the DAPO Center.

Exceptions

Opioid prescription fill limit exceptions are covered for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

Members enrolled in the Benchmark Plan, the Core Plan, and the Basic Plan are not eligible to receive an opioid prescription fill limit exception.

Schedule III-V drugs

If the prescriber is unavailable, the DAPO Center will grant a 96-hour supply exception to exceed the opioid monthly prescription fill limit for a Schedule III-V drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent) but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

If the prescriber is unavailable and the DAPO Center is closed, then pharmacy providers may dispense a 96 hour supply if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

Only one 96-hour supply exception for opioid drugs is allowed per calendar month. Once the DAPO Center is open, the pharmacy must call to obtain the 96-hour supply exception.

The 96-hour supply exception may be retroactive up to five days (i.e., back dated).

If a 96-hour supply exception has already been provided in the same calendar month, the prescription is a noncovered service.

Schedule II Drugs

If the prescriber is unavailable, the DAPO Center may grant an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contacted the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- An exception for Schedule II drugs was not previously granted within the current calendar month.
- The pharmacist may dispense the full quantity indicated on the prescription order.

If the prescriber is unavailable and the DAPO Center is closed, the pharmacy may dispense an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy documented on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.

- The pharmacist may dispense the full quantity indicated on the prescription order.

Pharmacy providers are required to submit a Noncompound Drug Claim (F-13072 (09/11)) form, with a Pharmacy Special Handling Request (F-13074 (04/11)) form, indicating the following:

- The drug dispensed was a Schedule II drug and the opioid monthly prescription fill limit was exceeded.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacist is required to provide justification why it was medically necessary to dispense the Schedule II opioid before discussing with the prescriber an exception to the opioid monthly prescription fill limit.

Only one exception for Schedule II opioid is allowed per calendar month.

If a Schedule II opioid exception has already been provided in the same calendar month, the prescription is a noncovered service.

Topic #523

Prescriber Information for Drug Prescriptions

Most legend and certain OTC (over-the-counter) drugs are covered. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Coverage for some drugs may be restricted by one of the following policies:

- PDL (Preferred Drug List).
- PA (prior authorization).
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age-restricted and gender-restricted drugs.

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

For the most current prescription drug information, refer to the pharmacy data tables. Providers may also call Provider Services for more information.

Preferred Drug List

Most preferred drugs on the PDL do *not* require PA, although these drugs may have other restrictions (e.g., age, diagnosis); non-preferred drugs *do* require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug.

Prescriber Responsibilities for Non-preferred Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate PA form and submit it to the

pharmacy provider where the prescription will be filled. When completing the PA form, prescribers are reminded to sign and date the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. The prescriber is required to attest on the form that the member meets the clinical criteria for PA approval. Prescribers should not submit PA forms to ForwardHealth.

Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

For BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan members, prescribers should be aware of drugs covered by the benefit plan and write prescriptions for drugs that are covered by the plan.

If a noncovered drug is medically necessary for a Benchmark Plan, Core Plan, or Basic Plan member, the prescriber should inform the member the drug is not covered by the benefit plan. The prescriber should instruct the member to work with his or her pharmacy provider to determine whether or not the drug is covered by BadgerRx Gold.

Diagnosis-Restricted Drugs

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

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

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the CMS (Centers for Medicare and Medicaid Services). BadgerCare Plus, Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs, except insulin.

ForwardHealth has identified drug manufacturers who have signed the rebate agreement. By signing the rebate agreement, the manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

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

Members Enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2a may cover certain FDA (Food and Drug Administration)-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

To submit a PA request for a drug without a signed rebate agreement, the prescriber should complete and submit the PA/DGA (Prior Authorization/Drug Attachment, F-11049 (10/08)) to the pharmacy where the drug will be dispensed. Pharmacies should complete the PA/RF and submit both forms and any supporting documentation to ForwardHealth. PAs can be submitted by paper, fax, or on the ForwardHealth Portal.

Included with the PA, the prescriber is required to submit documentation of medical necessity and cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include the following:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results.

- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition.
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to treat the member's medical condition.

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the Noncompound Drug Claim (F-13072 (09/11)) indicating the actual NDC of the drug with the Pharmacy Special Handling Request (F-13074 (04/11)) form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

Members Enrolled in SeniorCare (Levels 2b and 3)

PA is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3. PA requests submitted for drugs without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3 will be returned to the providers unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Members Enrolled in the BadgerCare Plus Benchmark, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan

PA is not available for drugs that are not included on the BadgerCare Plus Benchmark Plan Product List, BadgerCare Plus Core Plan Product List, BadgerCare Plus Basic Plan Product List, and the BadgerCare Plus Core Plan Brand Name Drugs Quick Reference. PA requests submitted for noncovered drugs will be returned to providers unprocessed and the services will not be covered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act of 1990) (42 CFR Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care. ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a medical profile for each member. The prospective DUR system uses this profile to determine whether or not a prescribed drug may be inappropriate or harmful to the member. It is very important that prescribers provide up-to-date medical diagnosis information about members on medical claims to ensure complete and accurate member profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacist receives an alert, a response is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled. Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a list of drugs for which pharmacy providers are required to dispense a three-month supply. The same list includes drugs that may be (but are not required to be) dispensed in a three-month supply.

Member Benefits

When it is appropriate for the member's medical condition, a three-month supply of a drug benefits the member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications.
- Reducing the cost of member copayments.
- Requiring fewer trips to the pharmacy.
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (e.g., hypertension).

Prescribers are encouraged to write prescriptions for a three-month supply when appropriate for the member.

Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three-month supply. In certain instances, brand name drugs (e.g., oral contraceptives) may be dispensed in a three-month supply.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (i.e., PRN) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

Prescription Mail Delivery

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

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

Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the FDA as LTE (less-than-effective) or identical, related, or similar to LTE drugs.
- Drugs identified on the Wisconsin Negative Formulary.
- Drugs manufactured by companies who have not signed the rebate agreement.
- Drugs to treat the condition of ED (Erectile Dysfunction). Examples of noncovered drugs for ED are Viagra® and Cialis®.

SeniorCare

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few

differences. Unlike Medicaid, SeniorCare does not cover OTC drugs other than insulin.

Topic #4346

Tamper-Resistant Prescription Pad Requirement

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

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

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

To be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

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

Exclusions to Tamper-Resistant Prescription Pad Requirement

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

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

72-Hour Grace Period

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

Coordination of Benefits

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

Retroactive Medicaid Eligibility

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

Penalty for Noncompliance

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

Provider Numbers

Topic #3421

National Provider Identifier

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

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

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 CMS (Centers for Medicare and Medicaid Services) Web site includes more Type 1 and Type 2 NPI information.

Multiple Certifications

Some providers hold multiple certifications with Wisconsin Medicaid. 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. Wisconsin Medicaid 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.

The following additional data are required with an NPI when a single NPI corresponds to multiple certifications:

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

When conducting business with ForwardHealth following certification, a taxonomy code is required when the NPI reported to ForwardHealth corresponds to more than one certification and the provider's practice location ZIP+4 code does not uniquely identify the provider. Omission of the required data will cause claims and other transactions to be denied or delayed in processing.

Topic #5096

Taxonomy Codes

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

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

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

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance link found in the secure Provider area of the ForwardHealth Portal. Alternatively, providers may use the Provider Change of Address or Status (F-01181 (09/11)) form to report new taxonomy codes.

Most taxonomy code changes entered through demographic maintenance will take effect in real time; providers may use the new codes immediately on transactions. Providers who submit new taxonomy codes using the Provider Change of Address or Status form will need to check demographic maintenance to verify ForwardHealth has received and added the new taxonomy codes prior to using them on transactions.

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

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

Topic #5097

ZIP Code

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

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

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

Provider Rights

Topic #208

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 (Enrollment Verification System) methods, including calling Provider Services.

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to 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.

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DHCAA's (Division of Health Care Access and Accountability) 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.

Topic #210

Limiting the Number of Members

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

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

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA (Division of Health Care Access and Accountability) 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 DHS 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 (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

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

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

Recertification

Topic #8517

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.

Topic #8521

Checking the Status of a Recertification Application

Providers may check the status of their recertification on the ForwardHealth Portal by entering the ATN (application tracking number) 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 (specialized medical vehicle) 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 (personal identification number) 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.

Topic #8519

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 (application tracking number) 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 (personal identification number) 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.

Topic #8523

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.

Topic #8522

Recertification Completed by an Authorized Representative

A provider has several options for submitting information to the DHS (Department of Health Services), 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.

Topic #8520

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 (personal identification number) 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 (application tracking number) 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 (Portable Document Format) 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 (Department of Health Services).

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

Topic #211

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS (Department of Health Services) 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 (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The DHS (Department of Health Services) 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.

Topic #213

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid 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.

Topic #214

Withholding Payments

The DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, 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:01/03/2012

Claims:Adjustment Requests

Topic #814

Allowed Claim

An allowed claim (or adjustment request) contains at least one service that is reimbursable. Allowed claims display on the Paid Claims Section of the RA (Remittance Advice) with a dollar amount greater than "0" in the allowed amount fields. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

Topic #815

Denied Claim

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Topic #2445

Documentation for Review Requests

Documentation might include operative reports, descriptions of special circumstances, or other information. Write "dental review requested" on the adjustment form.

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim to adjust. Once 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.

Topic #513

Follow-Up

Providers who believe an error has occurred or their issues have not been satisfactorily resolved have the following options:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI (Electronic Data Interchange) Helpdesk for assistance with electronic adjustment requests.

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (10/08)) form.

Topic #816

Processing

Within 30 days of receipt, ForwardHealth generally reprocesses the original claim with the changes indicated on the adjustment request and responds on ForwardHealth remittance information.

Topic #514

Purpose

After reviewing both the claim and ForwardHealth remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate payments (overpayments and underpayments).
- To add and delete services.
- To supply additional information that may affect the amount of reimbursement.
- To request professional consultant review (e.g., medical, dental).

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

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

Definition

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 (Express Enrollment) 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 (Enrollment Verification System) 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 (Explanation of Benefits) code, providers should contact Provider Services for assistance.

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to ForwardHealth in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since both of the following are true:

- A cash refund does not provide documentation for provider records as an adjustment request does. (Providers may be required to submit proof of the refund at a later time.)
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

Topic #532

Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels.

ForwardHealth processes an adjustment request if the provider is all of the following:

- Medicaid certified on the DOS (date of service).
- 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 guide for the appropriate 837 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

For paper adjustment requests, providers are required to do the following:

- Submit an Adjustment/Reconsideration Request (F-13046 (10/08)) 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.

Topic #533

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA (Remittance Advice) for the claim to be adjusted and highlight the affected claim on the RA. If a copy of the RA is not available, providers should indicate the ICN (internal control number), the NPI (National Provider Identifier) (if applicable), and the payee ID from the RA for the claim to be adjusted. The check should be sent to the following address:

ForwardHealth
Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

Topic #531

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If ForwardHealth initiates an adjustment to recover overpayments, ForwardHealth remittance information will include details of the adjustment in the Claims Adjusted Section of the paper RA (Remittance Advice).

Topic #530

Requirements

As stated in 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.

Topic #8417

Voiding Claims

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

Responses

Topic #540

An Overview of the Remittance Advice

The RA (Remittance Advice) provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. ForwardHealth provides electronic RAs to providers on their secure ForwardHealth Portal accounts when at least one claim, adjustment request, or financial transaction is processed. RAs are generated from the appropriate ForwardHealth program when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper). Generally, payment information is released and an RA is generated by ForwardHealth no sooner than the first state business day following the financial cycle.

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RA.

RAs are accessible to providers in a TXT (text) format via the secure Provider area of the Portal. Providers are also able to download the RA from their secure provider Portal account in a new CSV (comma-separated values) format.

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) that is used for multiple 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.

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA (Remittance Advice) appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total for each section by adding the net amounts for all claims listed in that section. Cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

Note: Some cutbacks that are reported in detail lines will appear as EOB (Explanation of Benefits) codes and will not display an exact dollar amount.

Topic #534

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN (internal

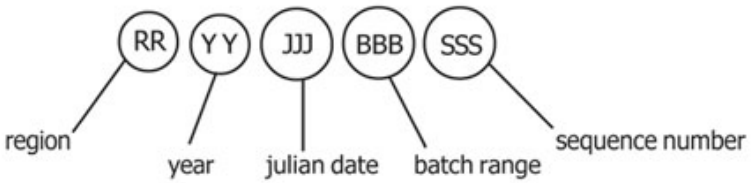
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

Each claim and adjustment received by ForwardHealth is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

Claim Status

ForwardHealth generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a claim or adjustment request using the AVR (Automated Voice Response) system or the 276/277 (276/277 Health Care Claim Status Request and Response) transaction.

If a claim or adjustment request does not appear in claim status within 45 days of the date of submission, a copy of the original claim or adjustment request should be resubmitted through normal processing channels.

Topic #644

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 (Explanation of Benefits) codes specific to the ClaimCheck review appear in the TXT (text) RA (Remittance Advice) file and in the electronic 835 (835 Health Care Claim Payment/Advice) 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.
- 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 (Repair, intermediate, wounds of scalp, axillae, trunk and/or

extremities [excluding hands and feet]; 12.6 cm to 20.0 cm) and 12036 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 20.1 cm to 30.0 cm), ClaimCheck rebundles them to procedure code 12037 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 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 (evaluation and management) services are reported separately when a substantial diagnostic or therapeutic procedure is performed. Under CMS (Centers for Medicare and Medicaid Services) 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 (Current Procedural Terminology) procedure ranges 92002-92019, 99024 (postoperative follow-up), 99026-99058 (special services), 99201-99456 (E&M codes) and HCPCS (Healthcare Common Procedure Coding System) 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 (date of service). 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 (American College of Surgeons) as its primary source for determining assistant surgeon designations. ForwardHealth's list of procedure codes allowable with an assistant surgeon designation is 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. ForwardHealth has adopted 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 (F-13046 (10/08)), with supporting documentation and the words, "medical consultant review requested" written on the form, to Provider Services Written Correspondence.

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member 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 (Remittance Advice); the detail line EOB (Explanation of Benefits) codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 (835 Health Care Claim Payment/Advice) transactions will be able to see all deducted amounts on paid and adjusted claims.

Topic #537

Electronic Remittance Information

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RAs (Remittance Advices). Electronic RAs on the Portal are not available to the following providers because these providers are not allowed to establish Portal accounts by their Provider Agreements:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.

RAs are accessible to providers in a TXT (text) format or from a CSV (comma-separated values) file via the secure Provider area of the Portal.

Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the "View Remittance Advices" menu. RAs from the last 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 "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.

Refer to the CSV User Guide on the Portal User Guides page of the Portal for instructions about Microsoft Office Excel functions that can be used to manipulate RA data downloaded from the CSV file.

835

Electronic remittance information may be obtained using the 835 (835 Health Care Claim Payment/Advice) transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a real-time compound or noncompound claim will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) software allows providers to download the 835 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #4822

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

EOB (Explanation of Benefits) codes are four-digit numeric codes specific to ForwardHealth that correspond to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail.

The claim processing sections of the RA (Remittance Advice) report EOBs for the claim header information and detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS (date of service) that the claim covers or the total amount paid for the claim. Detail lines report information from the claim details, such as specific procedure codes or revenue codes, the amount billed for each code, and the amount paid for a detail line item.

Header EOBs are listed below the claim header information and pertain only to the header information. Detail line EOBs are listed after each detail line and pertain only to the detail line.

TEXT File

EOB codes and descriptions are listed in the RA information in the TXT (text) file.

CSV File

EOB codes are listed in the RA information from the CSV (comma-separated values) file; however, the printed messages corresponding to the codes do not appear in the file. The EOB Code Listing matching standard EOB codes to explanation text is available on the Portal for reference.

Topic #4820

Identifying the Claims Reported on the Remittance Advice

The RA (Remittance Advice) reports the first 12 characters of the MRN (medical record number) and/or a PCN (patient control number), also referred to as Patient Account Number, submitted on the original claims. The MRN and PCN fields are located beneath the member's name on any section of the RA that reports claims processing information.

Providers are strongly encouraged to enter these numbers on claims. Entering the MRN and/or the PCN on claims may assist providers in identifying the claims reported on the RA.

Note: Claims processing sections for dental and drug claims do not include the MRN or the PCN.

Topic #11537

National Correct Coding Initiative

As part of the federal Patient Protection and Affordable Care Act of 2010, the CMS (Centers for Medicare and Medicaid Services) are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI (National Correct Coding Initiative) is the CMS response to this requirement. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT (Current Procedural Terminology) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all professional claims submitted with CPT or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits, for claims submitted on and after March 21, 2011, regardless of DOS (dates of service).
- Procedure-to-procedure detail edits for claims submitted on and after April 1, 2011, regardless of DOS.

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by McKesson ClaimCheck® and in ForwardHealth interChange.

Medically Unlikely Detail Edits

MUE, or units-of-service detail edits, define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single DOS. If a detail on a claim is denied for MUE, providers will

receive an EOB (Explanation of Benefits) code on the RA (Remittance Advice) indicating that the detail was denied due to NCCI.

An example of an MUE would be procedure code 11100 (i.e., biopsy of skin lesion). This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

Procedure-to-procedure detail edits define pairs of CPT/HCPCS codes that should not be reported together on the same DOS for a variety of reasons. This edit applies across details on a single claim or across different claims. For example, an earlier claim that was paid may be denied and recouped if a more complete code is billed for the same DOS on a separate claim. If a detail on a claim is denied for procedure-to-procedure edit, providers will receive an EOB code on the RA indicating that the detail was denied due to NCCI.

An example of a procedure-to-procedure edit would be procedure code 11451 (i.e., removal of a sweat gland lesion). This is a more complex service than procedure code 93000 (i.e., electrocardiogram) and, therefore, the secondary procedure would be denied.

Quarterly Code List Updates

The CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the CMS Web site for downloadable code lists.

Claim Details Denied as a Result of National Correct Coding Initiative Edits

Providers should take the following steps if they are uncertain about why particular services on a claim were denied:

- Review ForwardHealth remittance information for the EOB message related to the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications, including the Online Handbook, to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If reimbursement for a claim or a detail on a claim is denied due to an MUE or procedure-to-procedure edit, providers may appeal the denial. Following are instructions for submitting an appeal:

- Complete the Adjustment/Reconsideration Request (F-13046 (10/08)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs (Remittance Advice). The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. A separate Portal account is required for each financial payer.

Providers who do not have a ForwardHealth provider Portal account may request one.

RAs are accessible to providers in a TXT (text) format via the secure provider Portal account. The TXT format file is generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. RAs from the last 97 days are available in the TXT format.

Providers can also access RAs in a CSV (comma-separated values) format from their secure provider Portal account. The CSV files are generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. A separate CSV file is listed for the last 10 RAs.

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA (Remittance Advice) 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.

Claim Types on the Remittance Advice and Corresponding Provider Types

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services.
Drug and compound drug claims	Pharmacies and dispensing physicians.
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers.
Long term care claims	Nursing homes.
Medicare crossover institutional claims	Most providers who submit claims on the UB-04.
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form.
Outpatient claims	Outpatient hospital providers and hospice providers.
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups.

Topic #4821

Prior Authorization Number on the Remittance Advice

The RA (Remittance Advice) reports PA (prior authorization) numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

The Banner Messages section of the RA (Remittance Advice) contains important, time-sensitive messages for providers. For example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages; therefore, providers who receive multiple RAs should read all of their banner messages.

Banner messages appear on the TXT file, but not on the CSV (comma-separated values) file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB (Explanation of Benefits) code descriptions are listed in the RA information in the TXT file.

EOB codes are listed in the RA information from the CSV file; however, the printed messages corresponding to the codes do not appear in the file.

Financial Transactions Page

The Financial Transactions section details the provider's weekly financial activity. Financial transactions reported on the RA include payouts, refunds, accounts receivable, and payments for claims.

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (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 in the "Balance" column.

In the Accounts Receivable section, the "Amount Recouped In Current Cycle" column, when applicable, shows the recoupment amount for the financial cycle as a separate number from the "Recoupment Amount To Date." The "Recoupment Amount To Date" column shows the total amount recouped for each accounts receivable, *including* the amount recouped in the current cycle. The "Total Recoupment" *line* shows the sum of all recoupments to date in the "Recoupment Amount To Date" column and the sum of all recoupments for the current financial cycle in the "Amount Recouped In Current Cycle" column.

For each claim adjustment listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. This reflects the way ForwardHealth adjusts claims — by first recouping the entire amount of the original paid claim.

Each new claim adjustment is assigned an identification number called the "Adjustment ICN (internal control number)." For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the	V — Capitation adjustment

type of financial transaction that created the accounts receivable.	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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA (Omnibus Budget Reconciliation Act of 1987) Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA (Remittance Advice) if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

To adjust a claim, ForwardHealth recoups the *entire amount* of the original paid claim and calculates a new payment amount for

the claim adjustment. ForwardHealth does not recoup the *difference* — or pay the *difference* — between the original claim amount and the claim adjustment amount.

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

The Claim Adjustments section only lists detail lines for a claim adjustment if that claim adjustment has detail line EOBs. This section does not list detail lines for the original paid claim.

Note: For adjusted compound and noncompound claims, only the compound drug sections include detail lines.

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: "Additional Payment," "Overpayment To Be Withheld," or "Refund Amount Applied." The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

If the difference is a positive dollar amount, indicating that ForwardHealth owes additional monies to the provider, then the amount appears in the "Additional Payment" line.

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the "Overpayment To Be Withheld" line. ForwardHealth automatically withholds this amount from payments made to the provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under "Accounts Receivable."

An amount appears for "Refund Amount Applied" if ForwardHealth makes a payment to refund a cash receipt to a provider.

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA (Remittance Advice) if any of their claims were denied during the current financial cycle.

In the denied claims section, providers will see the original claim header information reported along with EOB (Explanation of Benefits) codes for the claim header and the detail lines, as applicable. Providers should refer to the EOB Code Description section of the RA to determine why the claim was denied.

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

```
REPORT:   CRA-HCDN-R                                  FORWARDHEALTH INTERCHANGE                                    DATE:  MM/DD/CCYY
  RA#:    999999999                                 <Financial Cycle Description>                                  PAGE:       9,999
 PAYER:   XXXX                                       PROVIDER REMITTANCE ADVICE
                                                   PROFESSIONAL SERVICE CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                            NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                             PAYMENT DATE       MM/DD/CCYY

  --ICN--         PCN           MRN        SERVICE DATES    BILLED          OTH INS         SPENDDOWN
                                            FROM   TO       AMOUNT          AMOUNT          AMOUNT

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY  999,999,999.99   9,999,999.99    999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                 SERVICE DATES                      PA NUMBER
PROC CD  MODIFIERS   ALLW UNITS  FROM   TO     RENDERING PROVIDER   BILLED AMT     DETAIL EOBS
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                   9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

            TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

Topic #4825

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA (Remittance Advice) if any of their claims were determined payable during the current financial cycle.

In a paid claims section, providers will see the original claim information reported along with EOB (Explanation of Benefits) codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined.

Sample Professional Services Claims Paid Section of the Remittance Advice

Remittance Advice — Professional Service Claims Paid Sample

```
REPORT:   CRA-HCPD-R                                  FORWARDHEALTH INTERCHANGE                                  DATE:  MM/DD/CCYY
  RA#:    999999999                                 <Financial Cycle Description>                                PAGE:       9,999
 PAYER:   XXXX                                        PROVIDER REMITTANCE ADVICE
                                                   PROFESSIONAL SERVICE CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                               PAYMENT DATE       MM/DD/CCYY

  --ICN--         PCN           MRN        SERVICE DATES      BILLED AMT      OTH INS AMT    COPAY AMT        PAID AMT
                                           FROM     TO        ALLOWED AMT    SPENDDOWN AMT   CO-INS CB       OUTPAT DED

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                            9,999,999.99       999,999.99     999,999.99       999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                     SERVICE DATES ALLW UNITS RENDERING PROVIDER        PA NUMBER
PROC CD  MODIFIERS   FROM   TO     COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT     DETAIL EOBS
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

            TOTAL PROFESSIONAL SERVICE CLAIMS PAID:       99,999,999.99    99,999,999.99   9,999,999.99    99,999,999.99
                                                          99,999,999.99     9,999,999.99   9,999,999.99     9,999,999.99
TOTAL NO. PAID: 999,999
```

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider ForwardHealth Portal accounts from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Topic #4827

Remittance Advice Generated by Payer and by Provider Certification

RAs (Remittance Advices) are generated and posted to secure provider Portal accounts from one or more of the following ForwardHealth financial payers:

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

- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

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 (National Provider Identifier) 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.

Topic #6237

Reporting a Lost Check

To report a lost check to ForwardHealth, providers are required to mail or fax a letter to ForwardHealth Financial Services. Providers are required to include the following information in the letter:

- Provider's name and address, including the ZIP+4 code.
- Provider's identification number.
  - For healthcare providers, include the NPI (National Provider Identifier) and taxonomy code.
  - For non-healthcare providers, include the provider identification number.
- Check number, check date, and check amount. (This should be recorded on the RA (Remittance Advice).)
- A written request to stop payment and reissue the check.
- The signature of an authorized financial representative. (An individual provider is considered his or her own authorized financial representative.)

Fax the letter to ForwardHealth at (608) 221-4567 or mail it to the following address:

ForwardHealth
Financial Services
6406 Bridge Rd
Madison WI 53784-0005

Topic #5018

Searching for and Viewing All Claims on the Portal

All claims, including compound, noncompound, and dental claims, are available for viewing on the ForwardHealth Portal.

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

- Go to the Portal.
- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may

select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Topic #4829

Sections of the Remittance Advice

The RA (Remittance Advice) information in the TXT (text) file includes the following sections:

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

The RA information in the CSV (comma-separated values) file includes the following sections:

- Payment.
- Payment hold.
- Service codes and descriptions.
- Financial transactions.
- Summary.
- Inpatient claims.
- Outpatient claims.
- Professional claims.
- Medicare crossovers — Professional.
- Medicare crossovers — Institutional.
- Compound Drug Claims.
- 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 (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)).
- The "Pay to" address of the provider. The "Pay to" address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle.
- The name of the RA section (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 (National Provider Identifier).
- The NPI of the provider, if applicable. This field will be blank for those providers who do not have an NPI.
- The number of the check issued for the RA, if applicable. The date of payment on the check, if applicable.

Topic #544

Verifying Accuracy of Claims Processing

After obtaining ForwardHealth remittance information, providers should compare it to the claims or adjustment requests to verify that ForwardHealth processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should do the following:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a member's account, providers should note the date on the ForwardHealth remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

Responsibilities

Topic #516

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.

Topic #366

Copayment Amounts

Copayment amounts collected from members should not be deducted from the charges submitted on claims. Providers should indicate their usual and customary charges for all services provided.

In addition, copayment amounts should not be included when indicating the amount paid by other health insurance sources.

The appropriate copayment amount is automatically deducted from allowed payments. Remittance information reflects the automatic deduction of applicable copayment amounts.

Topic #548

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 (Department of Health Services).
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.
- Reconsideration or recoupment.
- Retroactive enrollment for persons on GR (General Relief).
- Medicare denial occurs after ForwardHealth's submission deadline.
- Refund request from an other health insurance source.
- Retroactive member enrollment.

ForwardHealth has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing.

Topic #547

Submission Deadline

ForwardHealth recommends that providers submit claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

With few exceptions, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims. Members are not responsible for resolving claims. To resolve claims before the submission deadline, ForwardHealth encourages providers to use all available resources.

Claims

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS (date of service). This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Topic #517

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers 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, ForwardHealth automatically deducts the copayment amount.

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

Submission

Topic #2447

1500 Health Insurance Claim Form Instructions for Oral Surgery Services

A sample 1500 Health Insurance Claim Form is available for oral surgery services.

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. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Providers may use the 1500 Health Insurance Claim Form to bill for services that use both CPT (Current Procedural Terminology) and CDT (Current Dental Terminology) codes. **However, providers are required to submit claims on the ADA (American Dental Association) 2006 Claim Form if any procedures require a tooth number, surface information, or an area of oral cavity.**

Members enrolled in BadgerCare Plus or 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.

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 (Enrollment Verification System) 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 MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). 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 (Optical) 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 commercial insurance or dental ("DEN") insurance only, oral surgery prvoiders are required to indicate an OI (Other Insurance) explanation code.

If the EVS indicates that the member is enrolled in a Medicare Advantage Plan only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has any other 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: • 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
If an EOMB (Explanation of Medicare Benefits) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

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 a Medicare Advantage Plan, 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 EOMB, 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	**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. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as 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. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as 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	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance.

For Medicare Part A, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as 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).

For Medicare Part B, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as 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 (not required)

Element 17a — (not required)

Element 17b — NPI (not required)

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 classified) procedure code, a description of the procedure must be indicated in this element. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA (prior authorization) request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

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

Element 21 — Diagnosis or Nature of Illness or Injury
Enter a valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (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).

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 (dates of service) in MMDDYY or MMDDCCYY format. If the service was provided on only one DOS, 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 MMDDYY or MMDDCCYY format.

A range of dates may be indicated only if the POS (place of service), 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
Enter an "Y" for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

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 modifier in the "Modifier" column of Element 24D. The only modifier valid for oral surgery services is "80" (Assistant surgeon), which indicates when a provider assists at the surgery. Providers are required to use the ADA Claim Form when billing CDT codes that require a tooth number or an area of oral cavity.

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
Enter a "Y" for each family planning procedure. If family planning does not apply, leave this element blank.

Note: Providers should not use this element to indicate that a service is a result of a HealthCheck referral.

Element 24I — ID Qual
If the rendering provider's NPI (National Provider Identifier) is different than the billing provider NPI in Element 33a, enter a qualifier of "PXC," indicating provider taxonomy, in the *shaded area* of the detail line.

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.

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 MMDDYY or MMDDCCYY 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. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the NPI listed in Element 33a and match the practice location address on the provider's file maintained by ForwardHealth.

Element 33a — NPI
Enter the NPI of the billing provider.

Element 33b
Enter qualifier "PXC" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth. Do not include a space between the qualifier "PXC" and the provider taxonomy code.

Sample 1500 Health Insurance Claim Form for Oral Surgery Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY; SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 55555 TELEPHONE (Include Area Code): (444) 444-4444

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 213.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 02 11	11		21030		1	XXX XX	1		PXC	123456789X
										NPI	0111111110
2	11 02 11	11		41010		1	XXX XX	1		PXC	123456789X
										NPI	0111111110
3										PXC	
										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I. M. Provider 11302011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
a. 0222222220 b. PXC123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Topic #825

ADA 2006 Claim Form Completion Instructions

A sample ADA 2006 claim form is available for dental services.

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. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or 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.

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 single-page paper claims to the following address:

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

Submit completed multiple-page paper claims to the following address:

ForwardHealth
Multiple-Page Dental Claims
Ste 22
6406 Bridge Rd
Madison WI 53784-0002

HEADER INFORMATION

Element 1 — Type of Transaction (not required)

Element 2 — Predetermination/Preauthorization Number (not required)

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

Element 3 — Company/Plan Name, Address, City, State, Zip Code (not required)

OTHER COVERAGE

Element 4 — Other Dental or Medical Coverage (not required)

Element 5 — Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) (not required)

Element 6 — Date of Birth (MM/DD/CCYY) (not required)

Element 7 — Gender (not required)

Element 8 — Policyholder/Subscriber ID (SSN or ID#) (not required)

Element 9 — Plan/Group Number (not required)

Element 10 — Patient's Relationship to Person Named in #5 (not required)

Element 11 — Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Except for a few instances, ForwardHealth is the payer of last resort for any services covered by ForwardHealth. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing ForwardHealth unless the service is not covered by commercial health insurance. Element 11 identifies Medicare and commercial health insurance and whether the member has commercial health insurance coverage, Medicare coverage, or both.

There are specific instructions for each coverage type. Providers should use the following guidelines for this element depending on the member's coverage:

- Members with commercial health or dental insurance coverage.
- Members with Medicare coverage.
- Members with both Medicare and commercial health or dental insurance coverage.

Members with commercial health or dental insurance coverage
Commercial health or dental insurance coverage must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by Wisconsin's EVS (Enrollment Verification System) under "Other Commercial Health Insurance." ForwardHealth has defined a set of "other insurance" indicators. Additionally, ForwardHealth has identified specific CDT (Current Dental Terminology) codes must be billed to other insurance sources prior to being billed to ForwardHealth.

Note: When commercial health or dental insurance paid only for some services and denied payment for the others (or applied a payment to the member's coinsurance or deductible), ForwardHealth recommends that providers submit two separate claims. To maximize reimbursement, one claim should be submitted for the partially paid services and another claim should be submitted for the services that were denied.

The following table indicates appropriate other insurance codes for use in Element 11:

Code	Description
OI-P	PAID in part or in full by commercial health or dental insurance or commercial HMO. In Element 32 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.

OI-D	Use OI-D for dental claims in either of the following situations:
	• DENIED by commercial health or dental insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible.
	• YES, the member has commercial health or dental insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following:
	  ○ The member denied coverage or will not cooperate.
	  ○ The provider knows the service in question is not covered by the carrier.
	  ○ The member's commercial health or dental insurance failed to respond to initial and follow-up claims.
	  ○ Benefits are not assignable or cannot get assignment.
	  ○ Benefits are exhausted.

None	Providers may leave this element blank if none of the CDT procedure codes on the claim are listed as an allowable other insurance indicator or if the other insurance is vision only.

Note: The provider may not use OI-D 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.

Members with Medicare coverage
Submit claims to Medicare before submitting claims to ForwardHealth.

Do not enter a Medicare disclaimer code in Element 11 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does *not* have any Medicare coverage, including a Medicare Advantage Plan, 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 EOMB (Explanation of Medicare Benefits), but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements is true, a Medicare disclaimer code is necessary. The following table indicates appropriate Medicare disclaimer codes for use in Element 11 when billing Medicare prior to billing ForwardHealth.

Code	Description
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as 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. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as 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	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as 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). *For Medicare Part B, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as 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).

Members with both Medicare and commercial health or dental insurance coverage
Use both a Medicare disclaimer code ("M-7" or "M-8") and an other insurance explanation code (e.g., "OI-P") when applicable.

POLICYHOLDER/SUBSCRIBER INFORMATION

Element 12 — Policyholder/Subscriber Name (First, Last, Middle Initial, Suffix), Address, City, State, Zip Code
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. The member's address, city, state, and ZIP code are not required.

Element 13 — Date of Birth
Enter the member's birth date in MM/DD/CCYY format.

Element 14 — Gender (not required)

Element 15 — Policyholder/Subscriber ID (SSN or ID#)
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 16 — Plan/Group Number (not required)

Element 17 — Employer Name (not required)

PATIENT INFORMATION

Element 18 — Relationship to Policyholder/Subscriber in #12 Above (not required)

Element 19 — Student Status (not required)

Element 20 — Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code (not required)

Element 21 — Date of Birth (MM/DD/CCYY) (not required)

Element 22 — Gender (not required)

Element 23 — Patient ID/Account # (Assigned by Dentist) (not required)

RECORD OF SERVICES PROVIDED

Element 24 — Procedure Date (MM/DD/CCYY)
Enter the dates of service in MM/DD/CCYY format for each detail.

Element 25 — Area of Oral Cavity
If the procedure applies to gingivectomy, perio scaling, repair of dentures or partials, alveoplasty, or fixed bilateral space maintenance, the area of the oral cavity is entered here. or partials, or alveoplasty, the area of the oral cavity is entered here.

Element 26 — Tooth System (not required)

Element 27 — Tooth Number(s) or Letter(s)
If the procedure applies to only one tooth, the tooth number or tooth letter is entered here.

Element 28 — Tooth Surface
Enter the tooth surface(s) restored for each restoration.

Element 29 — Procedure Code
Enter the appropriate procedure code for each dental service provided.

Element 30 — Description

Write a brief description of each procedure.

Element 31 — Fee
Enter the usual and customary charge for each detail line of service.

Element 32 — Other Fee(s) (required for other insurance information, if applicable)
Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 32 is greater than zero, "OI-P" must be indicated in Element 11.) Do not include the copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows ForwardHealth to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 33 — Total Fee
Enter the total of all detail charges. Do not subtract other insurance payments.

MISSING TEETH INFORMATION

Element 34 — Permanent and Primary (Place an "X"on each missing tooth) (not required)

Element 35 — Remarks (required, if applicable)
List any unusual services, including reasons why limitations were exceeded. Providers should enter the word "Emergency" in this element for an emergency service.

AUTHORIZATIONS

Element 36 — Patient/Guardian Signature and Date (not required)

Element 37 — Subscriber Signature and Date (not required)

ANCILLARY CLAIM/TREATMENT INFORMATION

Element 38 — Place of Treatment (Check applicable box)
Check the appropriate box.

Element 39 — Number of Enclosures (00 to 99) (not required)

Element 40 — Is Treatment for Orthodontics? (not required)

Element 41 — Date Appliance Placed (MM/DD/CCYY) (not required)

Element 42 — Months of Treatment Remaining (not required)

Element 43 — Replacement of Prosthesis? (not required)

Element 44 — Date Prior Placement (MM/DD/CCYY) (not required)

Element 45 — Treatment Resulting from (Check applicable box) (required, if applicable)
Check the appropriate box if the dental services were the result of an occupational illness/injury, auto accident, or other accident.

Element 46 — Date of Accident (MM/DD/CCYY) (required, if applicable)
If a box was checked in Element 45, enter the date the accident happened.

Element 47 — Auto Accident State (required, if applicable)

Enter the state where the auto accident occurred.

BILLING DENTIST OR DENTAL ENTITY

Element 48 — Name, Address, City, State, Zip Code
Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 48 must correspond with the NPI (National Provider Identifier) in Element 49.

Element 49 — National Provider Identifier
Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name indicated in Element 48.

Element 50 — License Number (not required)

Element 51 — SSN or TIN (not required)

Element 52 — Phone Number (not required)

Element 52A — Additional Provider ID
Enter the billing provider's 10-digit taxonomy code. The taxonomy code in this element must correspond with the NPI indicated in Element 49.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Element 53 — Dentist's Signature and Date
The provider or the authorized representative must sign in Element 53. The month, day, and year the form is signed must also be entered in MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with a date. However, claims with "signature on file" stamps are denied.

Element 54 — NPI (required, if applicable)
If the treating provider's NPI is different than the billing provider NPI in Element 49, enter the treating provider's NPI in this element.

Element 55 — License Number (not required)

Element 56 — Address, City, State, Zip Code (not required)

Element 56A — Provider Specialty Code (required, if applicable)
Enter the treating provider's 10-digit taxonomy code. The taxonomy code in this element must correspond with the NPI indicated in Element 54.

Element 57 — Phone Number (not required)

Element 58 — Additional Provider ID (not required)

Sample ADA 2006 Claim Form for Dental Services

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination / Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
    OI-P

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    MEMBER, IM A
13. Date of Birth (MM/DD/CCYY)
    MM/DD/CCYY
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
    1234567890
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	11/18/2011					D0120	Exam - oral evaluation	XXX XX
2	11/18/2011					D1120	Prophylaxis	XX XX
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s) XX XX
33. Total Fee XXX XX

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
    Dental Group
    1 W. Williams St.
    Anytown, WI 55555-1234
49. NPI
    0111111110
50. License Number
51. SSN or TIN
52. Phone Number ( ) –
52A. Additional Provider ID 123456789X

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X *I. M. Provider* 11/30/2011
Signed (Treating Dentist) Date

54. NPI 0222222220
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code 123456789X
57. Phone Number ( ) –
58. Additional Provider ID

Sample

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Topic #542

Attached Documentation

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

Topic #6957

Copy Claims on the ForwardHealth Portal

Providers can copy institutional, professional, and dental paid claims on the ForwardHealth Portal. Providers can open any paid claim, click the "Copy" button, and all of the information on the claim will be copied over to a new claim form. Providers can then make any desired changes to the claim form and click "Submit" to submit as a new claim. After submission, ForwardHealth will issue a response with a new ICN (internal control number) along with the claim status.

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB (Explanation of Benefits) codes and descriptions for any claim submitted to ForwardHealth on the ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE (Direct Data Entry) on the ForwardHealth Portal:

- Professional claims.
- Institutional claims.
- Dental claims.
- Compound drug claims.
- Noncompound drug claims.

DDE is an online application that allows providers to submit claims directly to ForwardHealth.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes.
- Modifiers.
- Diagnosis codes.
- POS (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.
- POS.

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

- Diagnosis codes.
- NDCs (National Drug Codes).
- Place of service codes.
- Professional service codes.
- Reason for service codes.
- Result of service codes.

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME (durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS (Point-of-Sale) claims, are viewable via DDE.

Topic #344

Electronic 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.

Topic #2684

Dental Services

Electronic claims for dental services must be submitted using the 837D (837 Health Care Claim: Dental) transaction. Electronic claims for dental services submitted using any transaction other than the 837D will be denied.

Providers should use the companion guide for the 837D transaction when submitting these claims.

Oral Surgery CPT Codes

Electronic claims from oral surgeons who opt to submit claims with CPT (Current Procedural Terminology) codes are required to be submitted using the 837P (837 Health Care Claim: Professional) transaction. ForwardHealth denies electronic claims for oral surgery services performed by oral surgeons who opt to use CPT codes using any transaction other than the 837P.

Oral surgeons who choose this billing option should use the companion guide for the 837P transaction when submitting these claims.

Provider Electronic Solutions Software

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims using the 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #365

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO (health maintenance organization) or SSI (Supplemental Security Income) HMO and should be submitted to fee-for-service.

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

If the information in all fields is not valid and recognized by ForwardHealth, the claim will be denied.

Provider Numbers

For health care providers, NPIs (National Provider Identifiers) are required in all provider number fields on paper claims and 837 (837 Health Care Claim) transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV (specialized medical vehicle) providers, blood banks, and CCOs (community care organizations) should enter valid provider numbers into fields that require a provider number.

Topic #562

Managed Care Organizations

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

Topic #367

Noncertified Providers

Claims from noncertified in-state providers must meet additional requirements.

Topic #10837

Note Field for Most Claims Submitted Electronically

In some instances, ForwardHealth requires providers to include a description of a service identified by an unlisted, or NOC (not otherwise classified), procedure code. Providers submitting claims electronically should include a description of a NOC procedure code in a "Notes" field, if required. The Notes field allows providers to enter up to 80 characters. In some cases, the Notes field allows providers to submit NOC procedure code information on a claim electronically instead of on a paper claim or with a paper attachment to an electronic claim.

The Notes field should only be used for NOC procedure codes that do not require prior authorization.

Claims Submitted Via the ForwardHealth Portal Direct Data Entry or Provider Electronic Solutions

A Notes field is available on the ForwardHealth Portal DDE (Direct Data Entry) and PES (Provider Electronic Solutions) software when providers submit the following types of claims:

- Institutional.
- Professional.
- Dental.

On the Professional and Dental forms, a Notes field is available on each detail. On the Institutional form, the Notes field is only available on the header.

Claims Submitted Via 837 Health Care Claim Transactions

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in certain loops/segments on the 837 (837 Health Care Claim) transactions. Refer to the HIPAA (Health Insurance Portability and Accountability Act of 1996) Version 5010 Companion Guides on the Portal for more information.

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

Paper claims submitted to ForwardHealth on the 1500 Health Insurance Claim Form and UB-04 Claim Form are processed using

OCR (Optical Character Recognition) software that recognizes printed, alphanumeric text. OCR software increases efficiency by alleviating the need for keying in data from paper claims.

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (09/11)) and the Noncompound Drug Claim (F-13072 (09/11)).

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.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete items 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 0123456780

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. XX . XX XX . XX
2. XX . XX XX . XX
3. XX . XX XX . XX
4. XX . XX XX . XX

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										ZZ	123456789X
1	MM DD YY	XX		XXXXX	XX	X	XXX XX	1		NPI	0111111110
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) X MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID#) FECA BLK LUNG (SSN) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A.

3. PATIENT'S BIRTH DATE MM DD YY SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST.

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WI

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 55555 TELEPHONE (Include Area Code): XXX XXX-XXXX

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI: 0123456780

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. XX XX XX . XX 3. XX XX XX . XX

2. XX XX XX . XX 4. XX XX XX . XX

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY	XX		XXXXX	XX	X	XXX XX	1		NPI	ZZ 123456789X 0111111110
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
0222222220 ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Sample of a Correctly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER
1 W. WILSON
ANYTOWN WI 55555
(444) 444-4444

3a PAT CNTL # JED1234
b. MED REC # 03 765432
4 TYPE OF BILL XXX
5 FED TAX NO. 1234567890
6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME a MEMBER, IM A
9 PATIENT ADDRESS a 555 ORBITING DRIVE, WESTHILL, WI 52345
10 BIRTHDATE 07151955
11 SEX F
12 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACCT STATE 30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
550		XXXXX	MMDDYY	1	XXX XX		DD
580		XXXXX	MMDDYY	1	XXX XX		DD

PAGE ____ OF ____ CREATION DATE TOTALS XXX XX

50 PAYER NAME
MEDICARE
XYZ INSURANCE
T19 MEDICAID
51 HEALTH PLAN ID
54 PRIOR PAYMENTS XX XX
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID 87654321

58 INSURED'S NAME IM INSURED
60 INSURED'S UNIQUE ID 1234567890
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX XXXXX

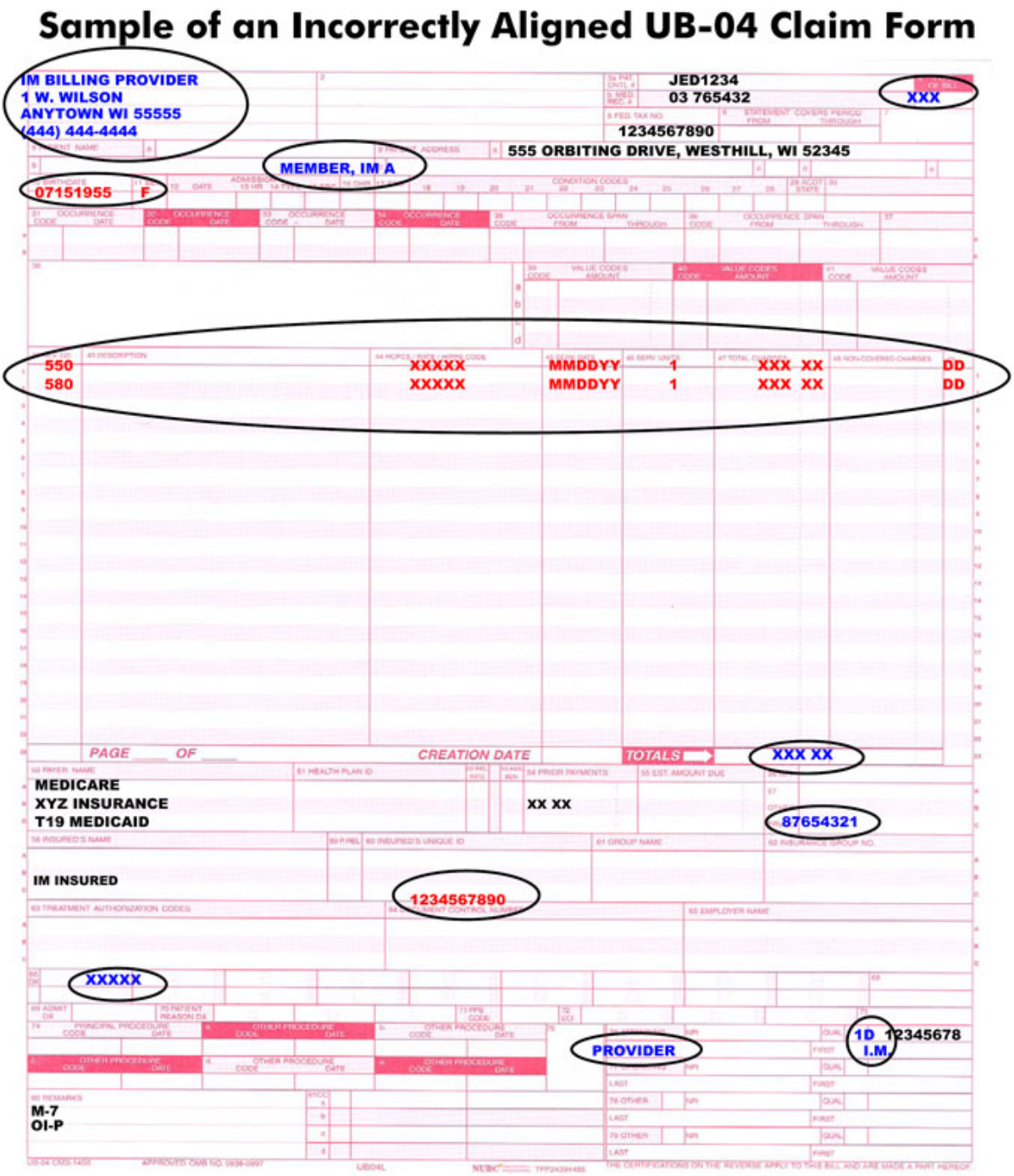
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL 1D 12345678
LAST PROVIDER FIRST I.M.
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
M-7

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04L NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



Topic #2704

Dental Services

Paper claims for dental services must be submitted using the ADA 2006 claim form. ForwardHealth denies paper claims for dental services submitted on any claim form other than the ADA 2006.

Providers should use ForwardHealth's ADA 2006 claim form completion instructions when submitting these claims.

Obtaining ADA 2006 Claim Form

ForwardHealth does not provide the ADA claim form. To order the ADA 2006 claim form, do one of the following:

- Call the ADA (American Dental Association) at (800) 947-4746.
- Order online at *www.adacatalog.org*.

Multiple-Page Paper ADA Claims

ForwardHealth recognizes that the number of dental procedures performed on a member on a single DOS (date of service) may exceed the number of details (line items where information about the services provided is indicated) available on a paper claim form. In such circumstances, providers may submit multiple-page paper claims containing up to 25 total details.

When submitting multiple-page paper dental claims, follow these instructions:

- Use the same type of paper claim form for all pages of the claim. The allowable paper claim form is the ADA 2006 claim form.
- Complete all of the claim form information on each page, including, but not limited to, the provider's identification number, the member's name, and the member's identification number.
- Staple additional pages behind the first page of the claim.
- Indicate the total amount billed for the entire claim on the last page of the claim.
- Mail multiple-page paper claims to the following address for specialized handling:

  ForwardHealth
  Multiple-Page Dental Claims
  Ste 22
  6406 Bridge Rd
  Madison WI 53784-0022

Note: Single-page paper dental claims should continue to be sent to the following address:

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

Oral Surgery CPT Codes

Oral surgeons who opt to submit paper claims with CPT (Current Procedural Terminology) codes are required to use the 1500 Health Insurance Claim Form (dated 08/05). ForwardHealth denies claims from oral surgeons who opt to submit paper claims with CPT codes on any claim form other than the 1500 Health Insurance Claim Form.

Providers should use the appropriate claim form instructions for oral surgery services when submitting these claims.

Obtaining the Claim Forms

ForwardHealth does not provide the 1500 Health Insurance Claim Form. The forms may be obtained from any federal forms supplier.

Topic #10177

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA (prior authorization) number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA (Remittance Advice) and the 835 (835 Health Care Claim Payment/Advice) report to the provider the PA number used to process a claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

When a PA requirement is added to the list of drugs requiring PA and the effective date of a PA falls in the middle of a billing period, two separate claims that coincide with the presence of PA for the drug must be submitted to ForwardHealth.

Topic #4382

Provider-Administered Drugs

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA (Deficit Reduction Act) of 2005 and submit NDCs (National Drug Codes) with HCPCS (Healthcare Common Procedure Coding System) procedure codes on claims for provider-administered drugs. Section 1927(a)(7)(B) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth, including Medicare crossover claims.

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

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

Radiopharmaceuticals are included in the DRA requirements. Providers will be required to indicate NDCs with HCPCS procedure codes on claims for radiopharmaceuticals.

Note: Vaccines are exempt from the DRA requirements. Providers who receive reimbursement under a bundled rate are not subject to the DRA requirements.

Less-Than-Effective Drugs

ForwardHealth will deny provider-administered drug claims for LTE (less-than-effective) or identical, related, or similar drugs for ForwardHealth members.

Medicare Crossover Claims

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

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

340B Providers

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

Explanation of Benefits Codes on Claims for Provider-Administered Drugs

Providers will receive an EOB (Explanation of Benefits) code on claims with a denied detail for a provider-administered drug if the claim does not comply with the standards of the DRA. If a provider receives an EOB code on a claim for a provider-administered drug, he or she should correct and resubmit the claim for reimbursement.

Provider-Administered Claim Denials

If a clinic's professional claim with a HCPCS code is received by ForwardHealth and a subsequent claim for the same drug is received from a pharmacy, having a DOS within seven days of the clinic's DOS (dates of service), then the pharmacy's claim will be denied as a duplicate claim.

Reconsideration of the denied drug claim may occur if the claim was denied with an EOB code and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim form along with the Pharmacy Special Handling Request form indicating the EOB code and requesting an override.

Provider-Administered Drugs and Administration Codes Reimbursed by Managed Care Organizations

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO (managed care organization), reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

This policy is known as the provider-administered drugs carve out policy. For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for "J" codes, drug-related "Q" codes, and administration code services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

Claims for dual eligibles should be submitted to Medicare first before they are submitted to ForwardHealth. Providers should continue to submit claims for other services to the member's MCO.

Provider-administered drugs and related services for members enrolled in the PACE (Program for All-Inclusive Care for the Elderly) and the Family Care Partnership are provided and reimbursed by the special managed care program.

Exemptions

Claims for drugs included in the cost of the procedure (e.g., a claim for a dental visit where lidocaine is administered) should be submitted to the member's MCO.

Vaccines and their administration fees are reimbursed by a member's MCO.

Providers who receive reimbursement under a bundled rate are reimbursed by a member's MCO.

Providers who were reimbursed a bundled rate by the member's MCO for certain services (e.g., hydration, catheter maintenance, TPN (total parenteral nutrition)) should continue to be reimbursed by the member's MCO. Provider should work with the member's MCO in these situations.

Additional Information

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

- CMS (Centers for Medicare and Medicaid Services) DRA information page.
- NUBC (National Uniform Billing Committee).
- NUCC (National Uniform Claim Committee).

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

- The FDA (Food and Drug Administration) Web site.
- The Drug Search Tool. (Providers may verify if an NDC and its segments are valid using this Web site.)
- The Noridian Administrative Services NDC to HCPCS crosswalk and the ASP (Average Sales Price) Drug Pricing Files.

Topic #10237

Claims for Provider-Administered Drugs

Claims for provider-administered drugs may be submitted to ForwardHealth via the following:

- A 1500 Health Insurance Claim Form.
- The 837P (837 Health Care Claim: Professional) transaction.
- The DDE (Direct Data Entry) on ForwardHealth Portal.
- The PES (Provider Electronic Solutions) software.

1500 Health Insurance Claim Form

NDCs for provider-administered drugs must be indicated in the shaded area of Elements 24A-24G on the 1500 Health Insurance Claim Form. The NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier "N4," followed by the 11-digit NDC of the drug dispensed, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

N412345678901 UN1234.567 is an example of what may be indicated in Elements 24A-24G of the 1500 Health Insurance Claim Form.

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for provider-administered drugs. If an NDC is not indicated on the claim, or if the NDC indicated is invalid, the claim will be denied.

837 Health Care Claim: Professional Transactions

Providers may refer to the NUCC (National Uniform Claim Committee) Web site for information about indicating NDCs on provider-administered drug claims submitted using the 837P transaction.

Direct Data Entry on the ForwardHealth Portal

The following must be indicated on provider-administered drug claims submitted using DDE on the Portal:

- The NDC of the drug dispensed.
- Quantity unit.
- Unit of measure.

Note: The "N4" NDC qualifier is not required on claims submitted on the Portal.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837P transactions, adjust claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #4817

Submitting Paper Attachments with Electronic Claims

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

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page (F-13470 (10/08)). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 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

This does not apply to compound and noncompound claims.

Topic #11677

Uploading Claim Attachments Via the Portal

Providers are able to upload attachments for most claims via the secure Provider area of the ForwardHealth Portal. This allows providers to submit all components for claims electronically.

Providers are able to upload attachments via the Portal when a claim is suspended and an attachment was indicated but not yet received. Providers are able to upload attachments for any suspended claim that was submitted electronically. Providers should

note that all attachments for a suspended claim must be submitted within the same business day.

Claim Types

Providers will be able to upload attachments to claims via the Portal for the following claim types:

- Professional.
- Institutional.
- Dental.

The submission policy for compound and noncompound drug claims does not allow attachments.

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with a ".rtf" extension; and PDF files must be stored with a ".pdf" extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

When a provider submits a DDE (Direct Data Entry) claim and indicates an attachment will also be included, a feature button will appear and link to the DDE claim screen where attachments can be uploaded.

Providers are still required to indicate on the DDE claim that the claim will include an attachment via the "Attachments" panel.

Claims will suspend for 30 days before denying for not receiving the attachment.

Claims Submitted by Provider Electronic Software and 837 Health Care Claim Transactions

Providers submitting claims via 837 (837 Health Care Claim) transactions are required to indicate attachments via the PWK segment. Providers submitting claims via PES (Provider Electronic Solutions) software will be required to indicate attachments via the attachment control field. Once the claim has been submitted, providers will be able to search for the claim on the Portal and upload the attachment via the Portal. Refer to the Implementation Guides for how to use the PWK segment in 837 transactions and the PES Manual for how to use the attachment control field.

Claims will suspend with 30 days before denying for not receiving the attachment.

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to submit a Timely Filing Appeals Request (F-13047 (10/08)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (10/08)) form to override the submission deadline.

DOS (dates of service) that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing and late DOS will be denied.

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (10/08)) cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Topic #744

Submission

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request (F-13047 (10/08)) form for each claim and each adjustment to allow for electronic documentation of individual claims and adjustments submitted to ForwardHealth.
- 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 (place of service) code, etc., as effective for the DOS (date of service). However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

The following table lists the filing deadlines and 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 (F-13046 (10/08)) form. The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 (Department of Health Services).	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:
	
	• 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:
	  ○ White paper BadgerCare Plus EE (Express Enrollment) for pregnant women or children identification card.
	  ○ Green paper temporary identification card.
	  ○ White paper TE (Temporary Enrollment) for Family Planning Only Services identification card.
	  ○ The response received through Wisconsin's EVS (Enrollment Verification System) 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 (Remittance Advice) 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 county or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following: • "GR retroactive enrollment" indicated on the claim. • A copy of the letter received from the local county or tribal agency.	ForwardHealth GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050

Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • 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**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

	• A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	

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

Coordination of Benefits

3

Archive Date:01/03/2012

Coordination of Benefits:Commercial Health Insurance

Topic #595

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.

Topic #844

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 (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Topic #598

Commercial Fee-for-Service

Fee-for-service commercial health insurance is the traditional health care payment system under which providers receive a payment for each unit of service provided rather than a capitation payment for each member. Such insurance usually does not restrict health care to a particular network of providers.

Topic #599

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 or Wisconsin Medicaid (i.e., state-contracted MCO (managed care organization), 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 and Wisconsin Medicaid 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.

Topic #601

Definition of Commercial Health Insurance

Commericial 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.

Topic #602

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.

Topic #596

Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Step 1. Determine if the Member Has Commercial Health Insurance
If Wisconsin's EVS (Enrollment Verification System) does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage. **If the member disputes the information as it is indicated in the EVS,** the provider should submit a completed Other Coverage Discrepancy Report (F-1159 (10/08)) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.
Step 2. Determine if the Service Requires Other Health Insurance Billing

If the service requires other health insurance billing, the provider should proceed to Step 3. **If the service does not require other health insurance billing,** the provider should proceed in one of the following ways: • The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3. • The provider may submit a claim without indicating an other insurance indicator on the claim. The provider may not bill ForwardHealth and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with ForwardHealth's ability to recover prior payments.
Step 3. Identify Assignment of Commercial Health Insurance Benefits
The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.) The provider should proceed in one of the following ways: • **If the provider is assigned benefits,** the provider should bill commercial health insurance and proceed to Step 4. • **If the member is assigned insurance benefits,** the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator. If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from ForwardHealth and the member, the provider is required to return the lesser amount to ForwardHealth.
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.

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

Sometimes a member's enrollment file shows commercial managed care coverage, but the member is unable to receive services from the managed care plan. Examples of such situations include the following:

- Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- Members enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.
- Members enrolled in a commercial managed care plan who enter a nursing facility that limits the member's access to

managed care providers.

In these situations, ForwardHealth will pay for services covered by both BadgerCare Plus or Medicaid and the commercial managed care plan even though the services are obtained from providers outside the plan.

When submitting claims for these members, providers should do one of the following:

- Indicate "OI-Y" on paper claims.
- Refer to the Wisconsin PES (Provider Electronic Solutions) Manual or the appropriate 837 (837 Health Care Claim) companion guide to determine the appropriate other insurance indicator for electronic claims.

Topic #604

Non-Reimbursable Commercial 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.

Topic #605

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed. Providers are required to use these indicators as applicable on professional, institutional, or dental 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 (Enrollment Verification System) indicates no commercial health insurance for the DOS (date of service).
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI (National Provider Identifier) and related data should be resolved with that payer and not submitted to ForwardHealth. Payments made in these situations may be recouped.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill commercial health insurance sources to substantiate other insurance indicators used on any claim, according to DHS 106.02(9)(a), Wis. Admin. Code.

Topic #4657

Other Insurance Indicators on the ADA 2006 Claim Form

The following is a list of the indicators and descriptions used by EVS (Wisconsin's Enrollment Verification System) to identify a member's other insurance coverage when filling out the ADA (American Dental Association) 2006 claim form:

- DEN — Commercial Dental Insurance.
- HMO — Health Maintenance Organization (non-Medicaid).
- SUP — Medicare Supplement.
- BLU — BlueCross and BlueShield.
- WPS — Wisconsin Physicians Service.
- CHA — TriCare.
- HPP — Wausau Health Protection Plan.
- OTH — All other commercial health or dental insurance plans.

Insurance Indicator "DEN"

When the EVS indicates the code "DEN" for "other coverage," submit claims for the following CDT (Current Dental Terminology) procedure codes to commercial dental insurance prior to billing these procedures to ForwardHealth.

Service Type	Service	Codes
Diagnostic	Exams	D0120-D0170
	X-rays	D0270-D0274
Preventive	Prophylaxis, Fluoride	D1110-D1202
	Sealants	D1351
	Space maintainers	D1510-D1515, D1550
Restorative	Fillings	D2140-D2394
	Crowns	D2390, D2920-D2933
Endodontic	Root canals	D3310-D3330
Periodontic	Gingivectomy	D4210-D4211
	Scaling	D4341-D4342
	Full-mouth debridement	D4355
Prosthodontic	Dentures	D5110-D5212, D5510-D5761
	Bridges	D6930-D6940, D6980-D6985
Extractions	Extractions	D7111-D7250
Surgical	Surgeries	D7260-D7780, D7840-D7850, D7910-D7991
Orthodontic	Orthodontia	D8010-D8680, D8692

Insurance Indicator "HMO"

When the EVS indicates the code "HMO" for "other coverage," submit claims for the following CDT procedure codes to the commercial HMO prior to billing these procedures to ForwardHealth. The provider must be a member of the commercial HMO to

receive reimbursement.

Service Type	Service	Codes
Diagnostic	Exams	D0120-D0170
Preventive	Cleanings	D1110-D1120
Restorative	Fillings	D2140-D2394
Oral and Maxillofacial Surgery	Extractions	D7111-D7250
Surgical	Surgeries	D7260-D7780, D7840-D7850, D7910-D7991

When the EVS indicates the code "SUP" for "other coverage," submit claims for the following CDT procedure codes to the member's commercial health or dental insurance prior to billing these procedures to ForwardHealth.

Service Type	Service	Codes
Adjunctive/General Services	Anesthesia	D9220, D9241

Insurance Indicators "BLU," "WPS," "CHA," "HPP," or "OTH"

When the EVS indicates either "BLU," "WPS," "CHA," "HPP," or "OTH" codes for "other coverage," submit claims for the following procedure codes to the member's commercial health or dental insurance prior to billing these procedures to ForwardHealth.

Service Type	Service	Codes
Adjunctive/General Services	Anesthesia	D9220, D9241

Topic #603

Services Not Requiring Commercial Health Insurance Billing

Providers are not required to bill commercial health insurance sources before submitting claims for the following:

- Case management services.
- CCS (Comprehensive Community Services).
- Crisis Intervention services.
- CRS (Community Recovery Services).
- CSP (Community Support Program) services.
- Family planning services.
- PNCC (prenatal care coordination) services.
- Preventive pediatric services.
- SMV (specialized medical vehicle) services.

Topic #769

Services Requiring Commercial Health Insurance Billing

If ForwardHealth indicates that the member has other commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF (skilled nursing facility).
- Blood bank services.
- Chiropractic services.
- Dental services.
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC (personal care) services).
- Hospice services.
- Hospital services, including inpatient or outpatient.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services for members who have Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS (place of service).
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF.
- Physician assistant services.
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient. However, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing.
- Pharmacy services for members with verified drug coverage.
- Podiatry services.
- PDN (private duty nursing) services for ventilator-dependent members.
- Radiology services.
- RHC (rural health clinic) services.
- Skilled nursing home care, if any DOS (date of service) 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 ForwardHealth indicates the member has other vision coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If ForwardHealth indicates the member has Medicare Supplemental Plan Coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Alcohol, betadine, and/or iodine provided by a pharmacy or medical vendor.
- Ambulance services.
- Ambulatory surgery center services.
- Breast reconstruction services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PC services).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.
- Skilled nursing home care, if any DOS is within 100 days of the date of admission. If benefits greater than 100 days are

available, the nursing home is required to continue to bill for them until those benefits are exhausted.

ForwardHealth has identified services requiring Medicare billing.

Medicare

Topic #664

Acceptance of Assignment

In Medicare, "assignment" is a process through which a provider agrees to accept the Medicare-allowed amount as payment in full. A provider who agrees to this amount is said to "accept assignment."

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member is required to accept assignment of the member's Medicare Part A benefits. Therefore, Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (i.e., any amount paid by other health insurance sources, any copayment or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount.

Topic #666

Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to ForwardHealth.

Topic #668

Claims Processed by Commercial 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.

Topic #670

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, professional, institutional, and dental claims should be submitted to ForwardHealth without first submitting them to Medicare in the following situations:

- The provider cannot be enrolled in Medicare.
- The service is not allowed by Medicare under any circumstance. Providers should note that claims are denied for services that Medicare has determined are not medically necessary.

In these situations, providers should not indicate a Medicare disclaimer code on the claim.

Topic #704

Claims That Fail to Cross Over

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA (Remittance Advice). Claims with an NPI (National Provider Identifier) that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

ForwardHealth is not able to identify the billing provider on automatic crossover claims submitted by health care providers in the following situations:

- The billing provider's NPI has not been reported to ForwardHealth.
- The taxonomy code has not been reported to ForwardHealth or is not indicated on the automatic crossover claim.
- The billing provider's practice location ZIP+4 code on file with ForwardHealth is required to identify the provider and is not indicated on the automatic crossover claim.

If automatic crossover claims do not appear on the 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 and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, copayment, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare DME (durable medical equipment) regional carrier.
- Medicare Advantage Plan.
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier).

There are two types of crossover claims based on who submits them:

- Automatic crossover claims.
- Provider-submitted crossover claims.

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC (Coordination of Benefits Contractor).

Claims will be forwarded if the following occur:

- Medicare has identified that the services were provided to a dual eligible or a QMB-Only member.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan.

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 (Remittance Advice) 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 or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- The NPI (National Provider Identifier) that ForwardHealth has on file for the provider.
- The taxonomy code that ForwardHealth has on file for the provider.
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth.

Providers may initiate a provider-submitted claim in one of the following ways:

- DDE (Direct Data Entry) through the ForwardHealth Provider Portal.
- 837I (837 Health Care Claim: Institutional) transaction, as applicable.
- 837P (837 Health Care Claim: Professional) transaction, as applicable.
- PES (Provider Electronic Solution) software.
- Paper claim form.

Topic #672

Definition of Medicare

Medicare is a health insurance program for people 65 years of age or older, for certain people with disabilities under age 65, and for people with ESRD (end-stage renal disease). Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- Part A (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 (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

Topic #684

Dual Eligibles

Dual eligibles are members who are eligible for coverage from Medicare (either Medicare Part A, Part B, or both) *and* Wisconsin Medicaid or BadgerCare Plus.

Dual eligibles may receive coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.
- BadgerCare Plus- or Medicaid-covered services, even those that are not allowed by Medicare.

Topic #669

Exhausting Medicare Coverage

Providers are required to exhaust Medicare coverage before submitting claims to ForwardHealth. This is accomplished by following these instructions. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim.

Adjustment Request for Crossover Claim
The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request (F-13046 (10/08)) 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 the do the following:
  - Attach Medicare's remittance information and refrain from indicating the Medicare payment.
  - Indicate "MMC (Medicare Managed Care)" 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 (F-13047 (10/08)) 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 or Wisconsin Medicaid, the provider may proceed as follows: • Bill commercial health insurance, if applicable. • Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. 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 occured: • Medicare reconsiders services that were previously not allowed. • Medicare retroactively determines a member eligible. In these situations, the provider should proceed as follows: • Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid. • Bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-Only) members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage 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 (Centers for Medicare and Medicaid Services) and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

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 (Explanation of Medicare Benefits). This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

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.

Topic #688

Medicare Disclaimer Codes

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles. Refer to claim instructions for Medicare disclaimer codes and their descriptions. The intentional misuse of Medicare disclaimer codes to obtain inappropriate reimbursement from ForwardHealth constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by ForwardHealth when Medicare benefits exist or when, for some valid reason, the provider is unable to obtain such benefits by reasonable means.

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim *directly* to ForwardHealth using the appropriate Medicare disclaimer code.

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.

Topic #689

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(7), 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 A 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.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-Only (Qualified Medicare Beneficiary-Only) members receive coverage from Wisconsin Medicaid only for services allowed by Medicare, providers who are not enrolled in Medicare are required to refer QMB-Only members to another certified provider who is enrolled in Medicare.

Topic #8457

Medicare Late Fees

Medicare assesses a late fee when providers submit a claim after Medicare's claim submission deadline has passed. Claims that cross over to ForwardHealth with a Medicare late fee are denied for being out of balance. To identify these claims, providers should reference the Medicare remittance information and check for ANSI (American National Standards Institute) code B4 (late filing penalty), which indicates a late fee amount deducted by Medicare.

ForwardHealth considers a late fee part of Medicare's paid amount for the claim because Medicare would have paid the additional amount if the claim had been submitted before the Medicare claim submission deadline. ForwardHealth will not reimburse providers for late fees assessed by Medicare.

Resubmitting Medicare Crossover Claims with Late Fees

Providers may resubmit to ForwardHealth crossover claims denied because the claim was out of balance due to a Medicare late fee. The claim may be submitted on paper, submitted electronically using the ForwardHealth Portal, or submitted as an 837 (837 Health Care Claim) transaction.

Paper Claim Submissions

When resubmitting a crossover claim on paper, include a copy of the Medicare remittance information so ForwardHealth can determine the amount of the late fee and apply the correct reimbursement amount.

Electronic Claim Submissions

When resubmitting a claim via the Portal or an electronic 837 transaction (including PES (Provider Electronic Solutions) software submissions), providers are required to balance the claim's paid amount to reflect the amount Medicare would have paid before Medicare subtracted a late fee. This is the amount that ForwardHealth considers when adjudicating the claim. To balance the claim's paid amount, add the late fee to the paid amount reported by Medicare. Enter this amount in the Medicare paid amount field.

For example, the Medicare remittance information reports the following amounts for a crossover claim:

- Billed Amount: $110.00.
- 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.

Topic #690

Medicare Retroactive Eligibility

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any payments for the retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

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

Topic #692

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They are eligible for coverage from Medicare (either Part A, Part B, or both) *and* limited coverage from Wisconsin Medicaid. QMB-Only members receive Medicaid coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, 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.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

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

Total payment for a Medicare Part B-covered service (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-covered 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 three examples of how the limitations are applied.

Reimbursement for Coinsurance or Copayment of Medicare Part B-Covered Services			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (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 (dates of service) 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.

Inpatient Hospital Services

State law limits reimbursement for coinsurance, copayment and deductible of Medicare Part A-covered inpatient hospital services for dual eligibles and QMB-Only members.

Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (i.e., any amount paid by other health insurance sources, any copayment or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance, copayment, and deductible of a Medicare Part A-covered inpatient hospital service is the *lesser* of the following:

- The difference between the *Medicaid*-allowed amount and the *Medicare*-paid amount.
- The sum of Medicare coinsurance, copayment, and deductible.

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

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles

Explanation	Example		
	1	2	3
Provider's billed amount	$1,200	$1,200	$1,200
Medicare-allowed amount	$1,000	$1,000	$1,000
Medicaid-allowed amount (e.g., diagnosis-related group or per diem)	$1,200	$750	$750
Medicare-paid amount	$1,000	$800	$500
Difference between Medicaid-allowed amount and Medicare-paid amount	$200	($-50)	$250
Medicare coinsurance, copayment and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Topic #770

Services Requiring Medicare Billing

If Wisconsin's EVS (Enrollment Verification System) indicates Medicare + Choice, the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory surgery center services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PC (personal care) services).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.

If the EVS indicates Medicare Cost, 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

Topic #4940

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report (F-1159 (10/08)), ForwardHealth confirms the information and updates the member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- The provider verifies through Wisconsin's EVS (Enrollment Verification System) that the member's other coverage information has been updated.
- The provider receives a written explanation.

Topic #4941

Coverage Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Topic #609

Insurance Disclosure Program

ForwardHealth receives policyholder files from most major commercial health insurance companies on a monthly basis. ForwardHealth then compares this information with member enrollment files. If a member has commercial health insurance, ForwardHealth revises the member's enrollment file with the most current information.

The insurance company is solely responsible for the accuracy of this data. If the insurance company provides information that is not current, ForwardHealth's files may be inaccurate.

Topic #610

Maintaining Accurate and Current Records

ForwardHealth uses many sources of information to keep accurate and current records of a member's other coverage, including the following:

- Insurance Disclosure program.
- Providers who submit an Other Coverage Discrepancy Report (F-1159 (10/08)) form.
- Member certifying agencies.
- Members.

The information about a member's other health insurance coverage in the member files may be incomplete or incorrect if ForwardHealth received inaccurate information from the other health insurance source or the member's certifying agency.

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report (F-1159 (10/08)) form. Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by Wisconsin's EVS (Enrollment Verification System).
- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (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 (managed care organization).

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Provider-Based Billing

Topic #660

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in DHS 106.03(7), Wis. Admin. Code.

Topic #658

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at (608) 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.

Topic #661

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- A notification letter.
- A Provider-Based Billing Summary. The Summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim.
- 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.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS (dates of service) that are within claims submission deadlines, providers should refer to the first table. For DOS that are

beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS (Wisconsin's Enrollment Verification System) that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do *not* 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 other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report (F-1159 (10/08)) form. • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do *not* use the prepared provider-based billing claim).	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

Beyond 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 (do *not* use the prepared provider-based billing claim). • A Timely Filing Appeals Request (F-13047 (10/08)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The provider discovers that the member's other coverage	• An Other Coverage Discrepancy Report form. • *After* using the EVS to verify that the member's	Send the Other Coverage Discrepancy Report form to the

information (i.e., enrollment dates) reported by the EVS is invalid.	other coverage information has been updated, include both of the following: ○ A claim (do *not* use the prepared provider-based billing claim.) ○ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • 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.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The other health insurance source denies the provider-based billing claim.	• A claim (do *not* 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: ○ 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.	• A claim (do *not* 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

Topic #662

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or enddated 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 enddated the other health insurance coverage from the member's file.	• The Provider-Based Billing Summary. • Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• The Provider-Based Billing Summary.
	• One of the following:
	  ○ The name of the person with whom the provider spoke and the member's correct other coverage information.
	  ○ 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.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The DOS (date of service), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. *Note:* In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance	• The Provider-Based Billing Summary.	ForwardHealth

source denies the provider-based billing claim.	• Documentation of the denial, including any of the following:
	  ○ Remittance information from the other health insurance source.
	  ○ A letter from the other health insurance source indicating a policy termination date that precedes the DOS.
	  ○ Documentation indicating that the other health insurance source paid the member.
	  ○ A copy of the insurance card or other 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.
		Provider-Based Billing
		PO Box 6220
		Madison WI 53716-0220
		Fax (608) 221-4567

The other health insurance source fails to respond to the initial *and* follow-up provider-based billing claim.	• The Provider-Based Billing Summary. • Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

Topic #663

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider 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

Topic #657

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 and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Topic #829

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus or Wisconsin Medicaid, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Topic #826

Seeking Payment from Settlement

After choosing to seek payment from a settlement, the provider may *instead* submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Topic #827

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, 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

4

Archive Date:01/03/2012

Covered and Noncovered Services:Adjunctive General Services

Topic #2901

An Overview

BadgerCare Plus's coverage of adjunctive general services includes the following services:

- Anesthesia.
- Professional visits.
- Unclassified treatment.
- Miscellaneous services.

Adjunctive general services are only covered under BadgerCare Plus Standard Plan and Medicaid.

Topic #2887

Anesthesia Coverage for Children

Deep sedation, nitrous oxide inhalation, and conscious sedation (D9220, D9230, D9241, D9248) for members up to age 20 may be provided by oral surgeons and pediatric dentists. Only one of these services may be performed on the same DOS (date of service), per member.

Nitrous oxide inhalation is not reimbursable for members ages 21 and older.

Topic #2846

Inpatient and Outpatient Hospital Services

BadgerCare Plus covers inpatient and outpatient hospitalization on an emergency and non-emergency (elective) basis for all dental services.

Hospitalization for the express purpose of controlling apprehension is not a Medicaid-reimbursable service. This policy applies to inpatient or outpatient hospital and ASCs (ambulatory surgery centers).

Examples of conditions that providers are required to document in the member's medical record when providing treatment in a hospital include, but are not limited to, the following:

- Members with physical or developmental disabilities resulting in uncontrolled behavior.
- Children who require extensive operative procedures.
- Members who are hospitalized.
- A physician requests a dental consultation.
- Geriatric patients who require monitoring of vital signs.
- Members who have a medical history of uncontrolled bleeding, severe cerebral palsy, or uncontrolled diabetes.
- Members who require extensive oral and maxillofacial procedures, such as orthognathic surgery, cleft palate surgery, or TMJ (temporomandibular joint) surgery.

Hospital calls are limited to two visits per stay and are only allowable in hospitals and ASCs.

Topic #2902

Palliative (Emergency) Treatment

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, fever, or trauma. For BadgerCare Plus purposes, palliative (emergency) treatment is treatment of dental pain — minor procedures that do not fit into the restorative, endodontic, periodontic, or oral and maxillofacial surgery covered services described in this handbook. Palliative treatment and definitive treatment cannot be performed on the same tooth on the same DOS (date of service).

Codes

Topic #6717

Administration Procedure Codes for Provider-Administered Drugs

For provider-administered drugs administered to members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special MCOs (managed care organizations), the CPT (Current Procedural Terminology) administration procedure codes below should be indicated on claims submitted for reimbursement to BadgerCare Plus and Medicaid fee-for-service, not the member's MCO. Claims for administration procedure codes not indicated on the table below should be submitted to the member's MCO for reimbursement. Only services that are covered by ForwardHealth are reimbursed.

Code	Description
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373	intra-arterial
96374	intravenous push, single or initial substance/drug
96375	each additional sequential intravenous push of a new substance/drug
96376	each additional sequential intravenous push of the same substance/drug provided in a facility
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

Topic #2806

Area of Oral Cavity Codes

BadgerCare Plus has identified allowable areas of oral cavity codes for dental services providers.

Note: BadgerCare Plus does not require an area of oral cavity code for all dental services.

Area of Oral Cavity Code	**Description**
01	Maxillary
02	Mandibular
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

Topic #4377

Benchmark Plan Procedure Codes

Dental Services Covered Under the Benchmark Plan

The following tables list procedure codes that are reimbursed under the BadgerCare Plus Benchmark Plan's Dental Services benefit.

Dental services are only available for children under 19 years of age and pregnant women under the Benchmark Plan. A deductible of $200.00 applies to services other than preventive and diagnostic services and 50 percent cost-sharing applies after payment of the deductible. Only children are subject to the deductible and cost-sharing. Pregnant women are exempt from all cost-sharing. The benefit is limited to $750.00 per enrollment year based on the amount paid by the Benchmark Plan.

D0100-D0999 Diagnostic

Covered diagnostic services are identified by the allowable CDT (Current Dental Terminology) procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Clinical Oral Examinations				
D0120	Periodic oral evaluation — established patient	One per six-month period, per provider, for members under the age of 19. One per six-month period, per provider, for members up to age 12.	$32.00	No
D0140	Limited oral evaluation — problem focused	One per six months, per provider.	$47.00	No
D0150	Comprehensive oral evaluation — new or established patient	One per three years, per provider.	$50.00	No
D0160	Detailed and extensive oral evaluation — problem focused, by report	One per three years, per provider.	$65.00	No
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	Allowed once per year, per provider. Allowable in office or hospital POS (places of service).	$38.00	No
Radiographs/Diagnostic Imaging (Including Interpretation)				
D0210	Intraoral; complete series (including bitewings)	One per three years, per provider. Not billable within six months of other X-rays including D0220, D0230, D0240, D0270, D0272, D0274, and D0330 except in an emergency.[1] Panorex plus bitewings may be billed under D0210.	$90.00	No
D0220	periapical — first film	One per day. Not payable with D0210 on same DOS (date of service) or up to six months after.[2]	$19.00	No
D0230	periapical — each additional film	Up to three per day. Must be billed with D0220. Not payable with D0210 on same DOS or up to six months after.[2]	$15.00	No

D0240	occlusal film	Up to two per day. Not payable with D0210 on same DOS.	$25.00	No
D0250	Extraoral; first film	Emergency only, one per day.[1]	$30.00	No
D0260	each additional film	Emergency only, only two per day.[1] Must be billed with D0250.	manual	No
D0270	Bitewing(s); single film	One per day, up to two per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$20.00	No
D0272	two films	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$30.00	No
D0273	three films	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$36.00	No
D0274	four films	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]	$42.00	No
D0330	Panoramic film	One per day when another radiograph is insufficient for proper diagnosis. Not payable with D0210, D0270, D0272, D0273, or D0274.	$82.00	No
D0340	Cephalometric film	Orthodontia diagnosis only. Allowable for members up to age 20.	$80.00	No
D0350	Oral/facial photographic images	Allowable for members up to age 20. Allowable for orthodontia or oral surgery.	$35.00	No
Tests and Examinations				
D0470	Diagnostic casts	Orthodontia diagnosis only. Allowed with PA (prior authorization) for members ages 21 and over, at BadgerCare Plus' request (e.g., for dentures).	$66.00	No
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	None	$175.00	No
D0999*	Unspecified diagnostic procedure, by report	Use this code for up to two additional oral exams per year with a HealthCheck referral. Allowable for members ages 13-20. Use for dental hygienists to report oral screening or preliminary exam. Limited to one per member, per provider, per year. No age restrictions.	$38.00	No

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

1 Retain records in member files regarding nature of emergency.

2 Six-month limitation may be exceeded in an emergency.

D1000-D1999 Preventive

Covered preventive services are identified by the allowable CDT procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Dental Prophylaxis				
D1110*	Prophylaxis; adult	One per 12-month period, per provider, for members ages 21 and older. One per six-month period, per provider, for members ages 13-20. Allowable for members ages 13 and older. Not payable with periodontal scaling and root planing or periodontal maintenance procedure. *Special Circumstances:* Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for Medicaid-certified dental hygienists.	$60.00	No
D1120*	child	One per six-month period, per provider. Allowable for members up to age 12. *Special Circumstances:* Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for Medicaid-certified dental hygienists.	$45.00	No
Topical Fluoride Treatment (Office Procedure)				
D1203+	Topical application of fluoride (prophylaxis not included); child	Two per 12-month period, per provider. Allowable for members up to age 12. *Special Circumstances:* Up to four per 12-month period, per provider, for cases of demonstrated high need, or for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene or demonstrated high need. Allowable for Medicaid-certified dental hygienists, physicians, and RNs (nurses).	$26.00	No
D1204*	adult	Two per 12-month period, per provider, for members ages 13-20. Covered only in special circumstances for members ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for members age 13 or older. Allowable for Medicaid-certified dental hygienists.	$27.00	No

D1206*	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	Up to four per 12-month period, per provider, for at risk children ages 0-20. Up to two per 12-month period, per provider, for children up to age 12. Up to four per 12-month period, per provider, for children up to age 12 for cases of demonstrated high need or permanently disabled members. Covered only in special circumstances for members ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Not payable with periodontal scaling and root planing. Allowable for Medicaid-certified dental hygienists. Per CDT, not used for desensitization.	$27.00	No
Other Preventive Services				
D1351*	Sealant — per tooth	Retain documentation regarding medical necessity of sealants placed on teeth other than permanent molars (1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, AS-TS). Allowable for members up to age 20. Narrative required in order to exceed once per three-year limitation. Allowable for Medicaid-certified dental hygienists.	$35.00	No
Space Maintenance (Passive Appliances)				
D1510	Space maintainer; fixed-unilateral	First and second primary molar only (tooth letters A, B, I, J, K, L, S, and T only). Limited to four per DOS; once per year, per tooth. Narrative required to exceed frequency limitation. Allowable for members up to age 20.	$210.00	No
D1515	fixed-bilateral	Once per year, per arch. Narrative required to exceed frequency limitation. Allowable for members up to age 20.	$300.00	No
D1550	Recementation of space maintainer	Limited to two per DOS. Allowable for members up to age 20.	$46.00	No

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

D2000-D2999 Restorative

Covered restorative services are identified by the allowable CDT procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Amalgam Restorations (Including Polishing)				
D2140	Amalgam; one surface, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-	$85.00	Yes

		TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).		
D2150	Two surfaces, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$103.00	Yes
D2160	Three surfaces, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$125.00	Yes
D2161	Four or more surfaces, primary or permanent	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).	$150.00	Yes
Resin-Based Composite Restorations — Direct				
D2330	Resin-based composite; one surface, anterior	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class I and Class V only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).	$100.00	Yes
D2331	two surfaces, anterior	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class III only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).	$125.00	Yes
D2332	three surfaces, anterior	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class III and Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).	$151.00	Yes
D2335	four or more surfaces or involving incisal angle (anterior)	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for	$184.00	Yes

		Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only). Must include incisal angle. Four surface resins may be billed under D2332, unless an incisal angle is included.		
D2390	Resin-based composite crown, anterior	Primary teeth: Once per year, per tooth (tooth letters D-G, DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11, 22-27, 56-61, 72-77 only.) Limitation can be exceeded with narrative for children[1], and with PA for adults greater than age 20.[2]	$250.00	Yes
D2391	Resin-based composite — one surface, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$111.00	Yes
D2392	Resin-based composite — two surfaces, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$145.00	Yes
D2393	Resin-based composite — three surfaces, posterior	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$175.00	Yes
D2394	Resin-based composite — four or more surfaces, posterior	Primary teeth: Once per year, per provider, per tooth[1](tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).	$204.00	Yes

[1] Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity.

[2] Frequency limitation may be exceeded only with PA.

D4000-D4999 Periodontics

Covered periodontic services are identified by the allowable CDT procedure codes listed in the following table. BadgerCare Plus reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Surgical Services (Including Usual Postoperative Care)				
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).	$400.00	Yes
D4211	one to three contiguous teeth or bounded teeth spaces per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).	$151.00	Yes
Non-Surgical Periodontal Services				
D4341*	Periodontal scaling and root planing — four or more teeth per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for members ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in hospital or ambulatory surgical center POS. Limited to two quadrants per DOS when provided in an office, home, ECF (Extended Care Facility), or other POS, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or a disability that makes travel to the dentist difficult. Not payable with prophylaxis.	$175.00	Yes
D4342*	Periodontal scaling and root planing — one to three teeth, per quadrant	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for members ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in a hospital or ambulatory surgical center POS. Limited to two quadrants per DOS when provided in an office, home, ECF, or other POS, unless the PA request provides sound medical or other logical reasons, including long-distance travel to the dentist or a disability that makes travel to the dentist difficult. Not payable with prophylaxis.	$105.00	Yes
D4355*	Full mouth debridement to enable comprehensive evaluation and diagnosis	Full mouth code. Excess calculus must be evident on an X-ray. One per three years, per provider. Billed on completion date only. May be completed in one long appointment. No other periodontal treatment (D4341, D4342, or D4910) can be authorized immediately after this procedure. Includes tooth polishing. Not payable with prophylaxis. Allowable for members ages 13 and older. Allowable with PA for members ages 0-12.	$123.00	Yes

Other Periodontal Services				
D4910*	Periodontal maintenance	Prior authorization may be granted up to three years. Not payable with prophylaxis. Once per year in most cases. Allowable for members ages 13 and older.	$95.00	Yes

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

D7000-D7999 Oral and Maxillofacial Surgery

Covered oral and maxillofacial surgery services are identified by the allowable CDT procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Limitations and Requirements	Benchmark Plan Maximum Fee	Subject to $200.00 Deductible
Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Allowed only once per tooth (tooth numbers 1-32, A-T, 51-82, and AS-TS).	$100.00	Yes
Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)				
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Allowed only once per tooth (tooth numbers 1-32, A-T, 51-82 and AS-TS).	$181.80	Yes
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions				
D7810	Open reduction of dislocation	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.	Manual	Yes
D7820	Closed reduction of dislocation	Once per DOS. Operative report required.	$486.00	Yes
D7830	Manipulation under anesthesia	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.	$339.00	Yes
D7840	Condylectomy	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.	Manual	Yes
D7850	Surgical discectomy, with/without implant	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.	Manual	Yes
D7860	Arthrotomy	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.	$4,058.00	Yes
D7871	Non-arthroscopic lysis and lavage	Allowable only once per side (right and left) per three years.	$766.00	Yes
D7899	Unspecified TMD therapy, by report	Use this code for billing temporomandibular joint assistant surgeon. Procedure must be included in PA	Manual	Yes

		request for the surgery itself. Only allowable in hospital or ambulatory surgical center POS.		
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	None	$82.00	Yes
21050	Condylectomy, temporomandibular joint (separate procedure)	None	Manual	Yes
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	None	TBD	Yes
21070	Coronoidectomy (separate procedure)	None	$2,565.00	Yes
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	None	Manual	Yes
21242	Arthroplasty, temporomandibular joint, with allograft	None	Manual	Yes
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	None	$6,567.00	Yes
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	None	$369.00	Yes
21485	complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	None	Manual	Yes
21490	Open treatment of temporomandibular dislocation	None	Manual	Yes
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	None	Manual	Yes
29804	Arthroscopy, temporomandibular joint, surgical	None	$3,530.00	Yes

* Indicates procedure reimbursable to Medicaid-certified dental hygienist.

\+ Indicates procedure reimbursable to Medicaid-certified physicians, nurse practitioners, physician's assistants, HealthCheck providers, and FQHCs (federally qualified health centers).

Claims for traumatic injury will be reviewed on a case-by-case basis. Maximum allowable fees will be established at the time of approval.

Topic #6677

Core Plan and Basic Plan Dental Procedure Codes

The CDT (Current Dental Terminology) codes in the table below are covered under the BadgerCare Plus Core Plan and BadgerCare Plus Basic Plan only when performed as an emergency service. Under the Core Plan, these dental services are reimbursed fee-for-service, regardless of place of service.

Code	Description of Service

Clinical Oral Evaluations	
D0140	Limited oral evaluation - problem focused
Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Intraoral - complete series (including bitewings)
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical each additional film
D0240	Intraoral - occlusal film
D0250	Extraoral - first film
D0260	Extraoral - each additional film
D0270	Bitewing(s) - single film
D0272	Bitewings - two films
D0274	Bitewings -four films
D0290	Posterior-anterior or lateral skull and facial bone, survey film
D0322	Tomographic survey
D0330	Panoramic film
D0340	Cephalometric film
Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)	
D7111	Extraction, coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)

Topic #2807

Dental Hygienist Allowable Services

Dental hygienists may be reimbursed for the following procedures only:

- D1110 (Prophylaxis; adult).
- D1120 (Prophylaxis; child).
- D1203 (Topical application of fluoride [prophylaxis not included]; child).
- D1204 (Topical application of fluoride [prophylaxis not included]; adult).
- D1206 (Topical fluoride varnish; therapeutic application for moderate to high caries risk members).
- D1351 (Sealant - per tooth).
- D4341 (Periodontal scaling and root planing - four or more teeth per quadrant).
- D4342 (Periodontal scaling and root planing - one to three teeth, per quandrant).
- D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis).
- D4910 (Periodontal maintenance).
- D0999 (Unspecified diagnostic procedure, by report).

Procedure code D0999 must be used to indicate an oral screening or preliminary examination. The words "preliminary examination" or "oral screening" must be written in Element 30 of the ADA (American Dental Association) 2006 claim form. The reason these terms must be used on the claim form is because D0999 is also used to indicate a HealthCheck "Other Service." On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by ForwardHealth or that exceeds limitations. These services are called HealthCheck "Other Services." HealthCheck "Other Services" require PA (prior authorization). Use of the terms "preliminary examination" or "oral screening" indicates that services are not HealthCheck "Other Services" and do not require PA or a HealthCheck referral.

Providers are required to obtain PA for certain specified services before delivery of that service. The procedure codes that always require PA are D4341, D4342, and D4910. Procedure code D4355 requires PA when performed on children through the age of 12.

Refer to the appropriate dental service category (i.e., diagnostic, preventative, or periodontics) for coverage limitations.

Topic #2824

Diagnosis Codes

Current Dental Terminology Codes

Dentists are not required to indicate a diagnosis code on ADA (American Dental Association) 2006 claim forms, 837D (837 Health Care Claim: Dental) transactions, or on PA (prior authorization) requests with CDT (Current Dental Terminology) procedure codes.

Other Procedure Codes

Diagnosis codes indicated on the 1500 Health Insurance Claim forms and 837P (837 Health Care Claim: Professional) transactions (and PA requests when applicable) must be from the ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) coding structure. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis.

Providers are responsible for keeping current with diagnosis code changes. Those 1500 claims and 837P transactions (and PA requests when applicable) with CPT (Current Procedural Terminology) codes received without an allowable ICD-9-CM diagnosis code are denied.

Topic #2816

Modifiers

Oral surgeons and oral pathologists submitting 1500 Health Insurance Claim forms and 837P (837 Health Care Claim: Professional) transactions with CPT (Current Procedural Terminology) codes for oral surgeries are to use modifier "80" (Assistant surgeon) on claims to designate when a provider assists at surgery.

Topic #2841

Oral Surgery CPT Procedure Codes

Covered oral surgery services, identified by allowable CPT (Current Procedural Terminology) procedure codes, are listed in the following table. Oral surgeons, oral pathologists, and dentists electing CPT claims submission are required to indicate these codes

on claims instead of the ADA (American Dental Association) oral surgery codes that do not require tooth modifiers.

This is not a complete list of CPT codes covered under BadgerCare Plus Standard Plan and Medicaid. Not all of the codes are covered under BadgerCare Plus Benchmark Plan.

Procedure Code	Description	Allowable Modifier
15115	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	
15116	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	80 (Assistant surgeon)
15135	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	
15136	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	80
15155	Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	
15156	additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	
15157	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	
15175	Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children	
15176	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	80
42325	Fistulization of sublingual salivary cyst (ranula);	
42326	with prosthesis	

Topic #2449

Place of Service Codes for Oral Surgeons

Allowable POS (place of service) codes for oral surgery services are listed in the following table.

POS Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility

11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Facilities for Developmental Disabilities
61	Comprehensive Inpatient Rehabilitation Facility
71	Public Health Clinic
72	Rural Health Clinic

Topic #2814

Place of Treatment Codes

Medicaid-reimbursable dental services must be performed in an allowable place of treatment.

Place of Treatment	**Enter the Following:**
Office	Check the "Office" or "Provider's Office" box with an "X" and enter: • **"05"** for Indian Health Service Free-Standing Facility. • **"06"** for Indian Health Service Provider-Based Facility. • **"07"** for Tribal 638 Free-Standing Facility. • **"08"** for Tribal 638 Provider-Based Facility. • **"11"** for Office. • **"50"** for FQHC (Federally Qualified Health Center). • **"71"** for State or Local Public Health Clinic. • **"72"** for Rural Health Clinic.
Hospital	Check the "Hospital" box with an "X" and enter: • **"21"** for Inpatient Hospital. • **"22"** for Outpatient Hospital. • **"23"** for Emergency Room — Hospital. • **"51"** for Inpatient Psychiatric Facility.
	Check the "ECF" box with an "X" and enter:

ECF (Extended Care Facility)	• **"31"** for Skilled Nursing Facility. • **"32"** for Nursing Facility. • **"51"** for Inpatient Psychiatric Facility. • **"54"** for Intermediate Care Facility/Mentally Retarded.
Other	Check the "Other" box with an "X" and enter: • **"12"** for Home. • **"15"** for Mobile Unit. • **"24"** for Ambulatory Surgical Center.

Topic #2808

Standard Plan/Medicaid Diagnostic, Preventive, Restorative, Endodontics, Periodontics, General Codes

The following procedure codes are reimbursed under the BadgerCare Plus Standard Plan and Medicaid.

D0100-D0999 Diagnostic

Covered diagnostic services are identified by the allowable CDT (Current Dental Terminology) procedure codes listed in the following tables. Reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Clinical Oral Examinations			
D0120	Periodic oral evaluation	No	One per six-month period, per provider, for members under the age of 21.
D0140	Limited oral evaluation — problem focused	No	One per six months, per provider.
D0150	Comprehensive oral evaluation — new or established patient	No	One per three years, per provider.
D0160	Detailed and extensive oral evaluation — problem focused, by report	No	One per three years, per provider.
D0170	Re-evaluation limited, problem focused (established patient; not post-operative visit)	No	Allowed once per year, per provider. Allowable in office or hospital POS (place of service).
Radiographs/Diagnostic Imaging (Including Interpretation)			
D0210	Intraoral; complete series (including bitewings)	No[3]	One per three years, per provider. Not billable within six months of other X-rays including D0220, D0230, D0240, D0270, D0272, D0274, and D0330 except in an emergency.[1] Panorex plus bitewings may be billed under D0210.
D0220	periapical first film	No	One per day. Not payable with D0210 on same DOS or up to six months after.[2]
D0230	periapical each additional film	No	Up to three per day.

			Must be billed with D0220. Not payable with D0210 on same DOS or up to six months after.[2]
D0240	occlusal film	No	Up to two per day. Not payable with D0210 on same DOS.
D0250	Extraoral; first film	No	*Emergency only*, one per day.[1]
D0260	each additional film	No	*Emergency only*, only two per day.[1] Must be billed with D0250.
D0270	Bitewing(s); single film	No	One per day, up to two per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]
D0272	two films	No	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]
D0273	three films	No	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]
D0274	four films	No	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.[2]
D0330	Panoramic film	No[3]	One per day when another radiograph is insufficient for proper diagnosis. Not payable with D0210, D0270, D0272, D0273, or D0274.
D0340	Cephalometric film	No	Orthodontia diagnosis only. Allowable for members up to age 20.
D0350	Oral/facial photographic images	No	Allowable for members up to age 20. Allowable for orthodontia or oral surgery.
Tests and Examinations			
D0470	Diagnostic casts	No	Orthodontia diagnosis only. Allowed with PA (prior authorization) for members ages 21 and over, at BadgerCare Plus's request (e.g., for dentures).
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	No	None.
D0999	Unspecified diagnostic procedure, by report	Yes	HealthCheck "Other Service." Use this code for up to two additional oral exams per year with a HealthCheck referral. Allowable for members ages 13-20.

[1] Retain records in member files regarding nature of emergency.

[2] Six-month limitation may be exceeded in an emergency.

[3] The same DOS limitation may not be exceeded in an emergency.

D1000-D1999 Preventive

Covered preventive services are identified by the allowable CDT procedure codes listed in the following table. Reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Dental Prophylaxis			
D1110	Prophylaxis; adult	No	One per 12-month period, per provider, for ages 21 and older. One per six-month period, per provider, for ages 13-20. **Allowable for members ages 13 or older.** Not payable with periodontal scaling and root planing or periodontal maintenance procedure. *Special Circumstances: Up to four per 12-month period, per provider, for permanently disabled member.* *Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
D1120	child	No	One per six-month period, per provider. **Allowable for members up to age 12.** *Special Circumstances: Up to four per 12-month period, per provider, for permanently disabled members.* *Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
Topical Fluoride Treatment (Office Procedure)			
D1203	Topical application of fluoride (prophylaxis not included); child	No	Two per 12-month period, per provider. **Allowable for members up to age 12.** *Special Circumstances: Up to four per 12-month period, per provider, for cases of demonstrated high need, or for permanently disabled members.* *Retain documentation of disability that impairs ability to maintain oral hygiene or demonstrated high need.* *Allowable for Medicaid-certified dental hygienists, physicians, and nurses.*
D1204	adult	No	Two per 12-month period, per provider, for ages 13-20. *Covered only in special circumstances for ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled members.* *Retain documentation of disability that impairs ability to maintain oral hygiene.* **Allowable for members age 13 or older.** *Allowable for Medicaid-certified dental hygienists.*
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	No	Up to four per 12-month period, per provider, for at risk children ages 0-20. Up to two per 12-month period, per provider, for children up to age 12. Up to four per 12-month period, per provider, for children up to age 12 for cases of demonstrated high need or permanently disabled members.

			Covered only in special circumstances for ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled members. *Retain documentation of disability that impairs ability to maintain oral hygiene.* Not payable with periodontal scaling and root planing. *Allowable for Medicaid-certified dental hygienists.* Per CDT, not used for desensitization.
Other Preventive Services			
D1351	Sealant — per tooth	No	Retain documentation regarding medical necessity of sealants placed on teeth *other than* permanent molars (1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, AS-TS). **Allowable for members up to age 20.** Narrative required in order to exceed once per three-year limitation. *Allowable for Medicaid-certified dental hygienists.*
Space Maintenance (Passive Applicances)			
D1510	Space maintainer; fixed-unilateral	No	First and second primary molar only (tooth letters A, B, I, J, K, L, S, and T only). Limited to four per DOS; once per year, per tooth. Narrative required to exceed frequency limitation. Allowable for members up to age 20.
D1515	fixed-bilateral	No	Once per year, per arch. Narrative required to exceed frequency limitation. Allowable for members up to age 20. Applicable area of the oral cavity (either 01 [maxillary] or 02 [mandibular]) required on claim form.
D1550	Recementation of space maintainer	No	Limited to two per DOS. Allowable for members up to age 20.
D1555	Removal of fixed space maintainer	No	

D2000-D2999 Restorative

Covered restorative services are identified by the allowable CDT procedure codes listed in the following table. Reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Amalgam Restorations (Including Polishing)			
D2140	Amalgam; one surface, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).
D2150	two surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).

D2160	three surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).
D2161	four or more surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[1] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[1] (tooth numbers 1-32 and 51-82 only).
Resin-Based Composite Restorations — Direct			
D2330	Resin-based composite; one surface, anterior	No	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class I and Class V only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).
D2331	two surfaces, anterior	No	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class III only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).
D2332	three surfaces, anterior	No	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class III and Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).
D2335	four or more surfaces or involving incisal angle (anterior)	No	Primary teeth: Once per tooth, per year, per provider.[1] Permanent teeth: Once per tooth, per three years, per provider.[1] Allowed for Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only). Must include incisal angle. Four surface resins may be billed under D2332, unless an incisal angle is included.
D2390	Resin-based composite crown, anterior	No	Primary teeth: Once per year, per tooth (tooth letters D-G, DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11, 22-27, 56-61, 72-77 only.) Limitation can be exceeded with narrative for children[1], and with PA for adults greater than age 20.[2]
D2391	Resin-based composite — one surface, posterior	No	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
D2392	Resin-based composite — two surfaces, posterior	No	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per

			tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
D2393	Resin-based composite — three surfaces, posterior	No	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
D2394	Resin-based composite — four or more surfaces, posterior	No	Primary teeth: Once per year, per provider, per tooth[1] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[1] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
Crowns — Single Restorations Only			
D2791	Crown — full cast predominantly base metal	No	Once per year, per primary tooth; once per five years, per permanent tooth[2] (tooth numbers 1-32, A-T, 51-82, and AS-TS.) Reimbursement is limited to the rate of code D2933. Upgraded crown. No dentist is obligated to complete this type of crown.
Other Restorative Services			
D2910	Recement inlay, onlay or partial coverage restoration	No	Tooth numbers 1-32, 51-82 only.
D2915	Recement cast or prefabricated post and core	No	Tooth numbers 1-32, A-T, 51-82, AS-TS.
D2920	Recement crown	No	Tooth numbers 1-32, A-T, 51-82, AS-TS.
D2930	Prefabricated stainless steel crown; primary tooth	No	Once per year, per tooth (tooth letters, A-T and AS-TS only).[2]
D2931	permanent tooth	No	Once per five years, per tooth (tooth numbers 1-32 and 51-82 only).
D2932	Prefabricated resin crown	No	Primary teeth: Once per year, per tooth (tooth letters D-G and DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11, 22-27, 56-61, and 72-77 only.) Limitation can be exceeded with narrative for children[1], and with PA for adults older than age 20.[2]
D2933	Prefabricated stainless steel crown with resin window	No	Primary teeth: Once per year, per tooth (tooth letters D-G, DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11 and 56-61 only.) Limitation can be exceeded with narrative for children[1], and with PA for adults older than age 20.[2]
D2934	Prefabricated esthetic coated stainless steel crown — primary tooth	No	Once per year, per tooth. Allowable age less than 21. Tooth letters D-G and DS-GS only.
D2940	Sedative filling	No	Not allowed with pulpotomies, permanent restorations, or endodontic procedures (tooth numbers 1-32, A-T, 51-82, and

			AS-TS).
D2951	Pin retention — per tooth, in addition to restoration	No	Once per three years, per tooth (tooth numbers 1-32 and 51-82 only).[1]
D2952	Post and core in addition to crown, indirectly fabricated	No	Once per tooth, per lifetime, per provider. Tooth numbers 2-15, 18-31, 52-65, and 68-81 only. Cannot be billed with D2954.
D2954	Prefabricated post and core in addition to crown	No	Once per tooth, per lifetime, per provider. Tooth numbers 2-15, 18-31, 52-65, and 68-81 only. Cannot be billed with D2952.
D2971	Additional procedures to construct new crown under existing partial denture framework	No	Tooth numbers 2-15 and 18-31 only.
D2999	Unspecified restorative procedure, by report	Yes	HealthCheck "Other Service." Use this code for single-unit crown. Allowable for members ages 0-20.

[1] Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity.

[2] Frequency limitation may be exceeded only with PA.

D3000-D3999 Endodontics

Covered endodontic services are identified by the allowable CDT procedure codes listed in the following table. Reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Pulpotomy			
D3220	Therapeutic pulpotomy (excluding final restoration); removal of pulp coronal to the dentinocemental junction and application of medicament	No	Once per tooth, per lifetime. Primary teeth only (tooth letters A-T and AS-TS only).
D3221	Pulpal debridement, primary and permanent teeth	No	Allowable for tooth numbers 2-15, 18-31, 52-65, and 68-81 only. For primary teeth, use D3220. Not to be used by provider completing endodontic treatment.
D3222	Partial pulpotomy for apexogenesis — permanent tooth with incomplete root development	No	Allowable for members through age 12
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)			
D3310	Anterior (excluding final restoration)	No (see limitations)	Normally for permanent anterior teeth. May be used to bill a single canal on a bicuspid or molar (tooth numbers 2-15, 18-31, 52-65, and 68-81 only, once per tooth, per lifetime). Not allowed with sedative filling.

			Root canal therapy on four or more teeth require PA.
D3320	Bicuspid (excluding final restoration)	No (see limitations)	Normally for permanent bicuspid teeth. May be used to bill two canals on a bicuspid or molar (tooth numbers 2-5, 12-15, 18-21, 28-31, 52-55, 62-65, 68-71, and 78-81 only, once per tooth, per lifetime). Not allowed with sedative filling. Root canal therapy on four or more teeth require PA.
D3330	Molar (excluding final restoration)	Yes, if age >20	Not covered for third molars. Permanent teeth only (tooth numbers 2, 3, 14, 15, 18, 19, 30, 31, 53, 53, 64, 65, 68, 69, 80, and 81 only, once per tooth, per lifetime). Not allowed with sedative filling. Root canal therapy on four or more teeth require PA.
Apexification/Recalcification Procedures			
D3351	Apexification/recalcification; initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No	Permanent teeth only (tooth numbers 2-15, 18-31, 52-65, 68-81 only). Not allowable with root canal therapy. Bill the entire procedure under this code. Allowable for members ages less than 21.
Apicoectomy/Periradicular Services			
D3410	Apicoectomy/periradicular surgery; anterior	No	Permanent anterior teeth only (tooth numbers 6-11, 22-27, 56-61, and 72-77 only). Not payable with root canal therapy on the same DOS. Code does not include retrograde filling (D3430), which may be billed separately.
D3430	Retrograde filling — per root	No	Permanent anterior teeth only (tooth numbers 6-11, 22-27, 56-61, and 72-77 only). Not payable with root canal therapy on the same DOS.

D4000-D4999 Periodontics

Covered periodontic services are identified by the allowable CDT procedure codes listed in the following table. Reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

D9000-D9999 Adjunctive General Services

Covered adjunctive general services are identified by the allowable CDT procedure codes listed in the following table. Reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Surgical Services (Including Usual Postoperative Care)			
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
D4211	one to three contiguous teeth or bounded teeth spaces per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).

Non-Surgical Periodontal Service			
D4341	Periodontal scaling and root planing — four or more teeth per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for members ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in hospital or ambulatory surgical center POS. Limited to two quadrants per DOS when provided in an office, home, ECF (extended-care facility), or other POS, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or disability, which makes travel to the dentist difficult. Not payable with prophylaxis.
D4342	one to three teeth, per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for members ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in a hospital or ambulatory surgical center POS. Limited to two quadrants per DOS when provided in an office, home, ECF, or other POS, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or disability, which makes travel to the dentist difficult. Not payable with prophylaxis.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	No (see limitations)	Full mouth code. Excess calculus must be evident on an X-ray. One per three years, per provider. Billed on completion date only. May be completed in one long appointment. No other periodontal treatment (D4341, D4342, or D4910) can be authorized immediately after this procedure. Includes tooth polishing. Not payable with prophylaxis. Allowable for members ages 13 and older. Allowable with PA for members ages 0-12.
Other Periodontal Services			
D4910	Periodontal maintenance	Yes	PA may be granted up to three years. Not payable with prophylaxis. Once per year in most cases. Allowable for members ages 13 and older.
D4999	Unspecified periodontal procedure, by report	Yes	HealthCheck "Other Service." Use this code for unspecified surgical procedure with a HealthCheck referral. Allowable for members up to age 20.
Code	**Description of Service**	**Prior Authorization?**	**Limitations and Requirements**
Unclassified Treatment			
D9110	Not payable immediately before or	No	Not payable immediately before or after surgery.

	after surgery. Emergency only. Limited to once per member per date of service per rendering provider		Emergency only. Limit of $62.50 reimbursement per DOS for all emergency procedures done on a single DOS. Narrative required to override limitations.
Anesthesia			
D9220	Deep sedation/general anesthesia	Yes (see limitations)	PA not required in the following circumstances: 1. For hospital or ambulatory surgical center POS. 2. In an emergency.[1] 3. For children (ages 0-20), when performed by an oral surgeon or pediatric dentist. Entire procedure is reimbursed under this code (first 30 minutes and any additional minutes). D9221 "each additional 15 minutes" is not a covered service. Not billable to the member. Bill only D9220 for general anesthesia. Not payable with D9230, D9241, or D9248.
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	No	Allowable for children (ages 0-20), when performed by an oral surgeon or pediatric dentist. Not payable with D9220, D9241, or D9248.
D9241	Intravenous conscious sedation/analgesia	Yes (see limitations)	PA not required in the following circumstances: 1. For hospital or ambulatory surgical center POS. 2. In an emergency.[1] 3. For children (ages 0-20), when performed by an oral surgeon or pediatric dentist. Entire procedure is reimbursed under this code (first 30 minutes and any additional minutes). D9242 "each additional 15 minutes" is not a covered service. Not billable to the member. Bill only D9241 for intravenous sedation. Not payable with D9220, D9230, or D9248.
D9248	Non-intravenous conscious sedation	Yes (see limitations)	PA not required for children (ages 0-20), when performed by an oral surgeon or pediatric dentist. Not analgesia. Not payable with D9220, D9230, or D9241. Not inhalation of nitrous oxide.
Professional Visits			
D9410	House/extended care facility call	No	Reimbursed for professional visits to nursing homes and skilled nursing facilities. Only reimbursed for claims that indicate POS code 31 (skilled nursing facility) or 32 (nursing home). Service is limited to once every 333 days per member. Service must be performed by a Medicaid-certified dentist.
D9420	Hospital call	No	Up to two visits per stay. Only allowable in hospital and ambulatory surgical center POS.
Drugs			

D9610	Therapeutic parenteral drugs, single administration	No	
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	No	
Miscellaneous Services			
D9910	Application of desensitizing medicament	No	Tooth numbers 1-32, A-T, 51-82, and AS-TS. Limit of $62.50 reimbursement per DOS for all emergency procedures done on a single DOS. Narrative required to override limitations. Not payable immediately before or after surgery, or periodontal procedures (D4210, D4211, D4341, D4342, D4355, D4910). Cannot be billed for routine fluoride treatment. *Emergency only*.
D9999	Unspecified adjunctive procedure, by report	Yes	HealthCheck "Other Service." Use this code for unspecified non-surgical procedures with a HealthCheck referral.

[1]Retain records in member files regarding nature of emergency.

Topic #2818

Standard Plan/Medicaid Prosthodontics, Maxillofacial Prosthetics, Maxillofacial Surgery, and Orthodontics

The following procedure codes are covered under the BadgerCare Plus Standard Plan and Medicaid.

D5000-D5899 Prosthodontics, Removable

Covered removable prosthodontic services are identified by the allowable CDT (Current Dental Terminology) procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization	Limitations and Requirements
Complete Dentures (Including Routine Post-Delivery Care)			
D5110	Complete denture — maxillary	Yes	Allowed once per five years.[1, 2]
D5120	mandibular	Yes	Allowed once per five years.[1, 2]
Partial Dentures (Including Routine Post-Delivery Care)			
D5211	Maxillary (upper) partial denture; resin base (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[1, 2]
D5212	Mandibular (lower) partial denture; resin base (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[1, 2]
D5213	Maxillary partial denture; cast metal	Yes	Allowed once per five years.[1, 2] Reimbursement is limited to

	framework with resin denture bases (including any conventional clasps, rests and teeth)		reimbursement for D5211. Upgraded partial denture. No dentist is obligated to complete this type of partial.
D5214	Mandibular partial denture; cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[1, 2] Reimbursement is limited to reimbursement for D5212. Upgraded partial denture. No dentist is obligated to complete this type of partial.
D5225	Maxillary partial denture — flexible base (including any clasps, rests and teeth)	Yes	Allowed once per five years.[1, 2]
D5226	Mandibular partial denture — flexible base (including any clasps, rests and teeth)	Yes	Allowed once per five years.[1, 2]
Repairs to Complete Dentures			
D5510	Repair broken complete denture base	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5520	Replace missing or broken teeth — complete denture (each tooth)	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
Repairs to Partial Dentures			
D5610	Repair resin denture base	No	Limited to once per DOS. Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5620	Repair cast framework	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5630	Repair or replace broken clasp	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5640	Replace broken teeth — per tooth	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5650	Add tooth to existing partial denture	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5660	Add clasp to existing partial denture	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5670	Replace all teeth and acrylic on cast	Yes	Combined maximum reimbursement limit per six months for

	metal framework (maxillary)		repairs. Requires area of oral cavity code 01=Maxillary in the appropriate element of the claim form.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Yes	Combined maximum reimbursement limit per six months for repairs. Requires area of oral cavity code 02=Mandibular in the appropriate element of the claim form.
Denture Reline Procedures			
D5750	Reline complete maxillary denture (laboratory)	No	Allowed once per three years.[1] Retain documentation of medical necessity.
D5751	Reline complete mandibular denture (laboratory)	No	Allowed once per three years.[1] Retain documentation of medical necessity.
D5760	Reline maxillary partial denture (laboratory)	No	Allowed once per three years.[1] Retain documentation of medical necessity.
D5761	Reline mandibular partial denture (laboratory)	No	Allowed once per three years.[1] Retain documentation of medical necessity.

[1] Frequency limitation may be exceeded in exceptional circumstances with written justification on PA (prior authorization) request.
[2] Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in PA.

D5900-D5999 Maxillofacial Prosthetics

Covered maxillofacial prosthetics are identified by the allowable CDT procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
D5932	Obturator prosthesis; definitive	No	Allowed once per six months.[1] Retain documentation of medical necessity.
D5955	Palatal lift prosthesis, definitive	No	Allowed once per six months.[1] Retain documentation of medical necessity.
D5991	Topical medicament carrier	No	
D5999	Unspecified maxillofacial prosthesis, by report	Yes	For medically necessary removable prosthodontic procedures not listed. Lab bills and narrative required.

[1] Frequency limitation may be exceeded in exceptional circumstances with written justification on PA request.

D6200-D6999 Prosthodontics, Fixed

Covered fixed prosthodontic services are identified by the allowable CDT procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Fixed Partial Denture Pontics			
D6211	Pontic; cast predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
D6241	Pontic — porcelain fused to predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
Fixed Partial Denture Retainers — Inlays/Onlays			
D6545	Retainer; cast metal for resin bonded fixed prosthesis	Yes	Tooth numbers 1-32, 51-82 only.
Fixed Partial Denture Retainers — Crowns			
D6751	Crown; porcelain fused to predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
D6791	full cast predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
Other Fixed Partial Denture Services			
D6930	Recement fixed partial denture	No	
D6940	Stress breaker	Yes	Copy of lab bill required.
D6980	Fixed partial denture repair, by report	Yes	Copy of lab bill required.
D6985	Pediatric partial denture, fixed	No	Allowable up to age 12. Retain documentation of medical necessity.

D7000-D7999 Oral and Maxillofacial Surgery

Covered oral and maxillofacial surgery services are identified by the allowable CDT procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7111	Extraction, coronal remnants — deciduous tooth	No	Allowed only once per tooth. Primary teeth only (tooth letters A-T and AS-TS only). Not payable same DOS as D7250 for same tooth letter.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	Allowed only once per tooth (tooth numbers 1-32, A-T, 51-82 and AS-TS). Not payable same DOS as D7250 for same tooth number.
Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for same tooth number.
D7220	Removal of impacted tooth; soft tissue	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for the same tooth

			number.
D7230	partially bony	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for the same tooth number.
D7240	completely bony	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for the same tooth number.
D7250	Surgical removal of residual tooth roots (cutting procedure)	No	*Emergency only* (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Allowed only once per tooth. Not allowed on the same DOS as tooth extraction of same tooth number.
Other Surgical Procedures			
D7260 or CPT (Current Procedural Terminology)[2]	Oroantral fistula closure	No	Operative report required.
D7261	Primary closure of a sinus perforation	No	Operative report required.
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	No	*Emergency only* (tooth numbers 1-32, C-H, M-R, 51-82, CS-HS, and MS-RS).[1] Operative report required.
D7280	Surgical access of an unerupted tooth	No	Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, 52-65, and 68-81 only). Allowable for members ages 0-20. Operative report required.
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	No	Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, 52-65, and 68-81 only). Allowable for members ages 0-20. Operative report required.
D7283	Placement of device to facilitate eruption of impacted tooth	No	Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, 52-65, and 68-81 only). Allowable for members ages 0-20. Operative report required.
D7285 or CPT[2]	Biopsy of oral tissue; hard (bone, tooth)	No	Once per DOS.[3] Operative report required.
D7286 or CPT[2]	soft	No	Once per DOS.[3] Operative report required.
D7287 or CPT[2]	Exfoliative cytological sample collection	No	Once per DOS.[3] Operative report required.

D7288	Brush biopsy — transepithelial sample collection	No	Once per DOS.[3] Operative report required.
Alveoloplasty — Surgical Preparation of Ridge for Dentures			
D7310	Alveoloplasty in conjuction with extractions — per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
D7311	Alveoloplasty in conjuction with extractions — one to three teeth or tooth spaces, per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
D7320	Alveoloplasty not in conjuction with extractions — per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
D7321	Alveoloplasty not in conjuction with extractions — one to three teeth or tooth spaces, per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
Surgical Excision of Soft Tissue Lesions			
D7410 or CPT[2]	Excision of benign lesion up to 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7411 or CPT[2]	Excision of benign lesion greater than 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7412 or CPT[2]	Excision of benign lesion, complicated	No	Once per DOS.[3] Pathology report required.
D7413 or CPT[2]	Excision of malignant lesion up to 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7414 or CPT[2]	Excision of malignant lesion greater than 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7415 or CPT[2]	Excision of malignant lesion, complicated	No	Once per DOS.[3] Pathology report required.
Surgical Excision of Intra-Osseous Lesions			
D7440 or CPT[2]	Excision of malignant tumor; lesion diameter up to 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7441 or CPT[2]	lesion diameter greater than 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7450 or CPT[2]	Removal of benign odontogenic cyst or tumor; lesion diameter up to 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7451 or CPT[2]	lesion diameter greater than 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7460 or CPT[2]	Removal of benign nonodontogenic cyst or tumor; lesion diameter up to 1.25 cm	No	Once per DOS.[3] Pathology report required.
D7461 or CPT[2]	lesion diameter greater than 1.25 cm	No	Once per DOS.[3] Pathology report required.
Excision of Bone Tissue			
D7471 or	Removal of lateral exostosis (maxilla	Yes	Oral photographic image or diagnostic cast of arch required

CPT[2]	or mandible)		for PA.
D7472 or CPT[2]	Removal of torus palatinus	Yes	Oral photographic image or diagnostic cast of arch required for PA.
D7473 or CPT[2]	Removal of torus mandibularis	Yes	Oral photographic image or diagnostic cast of arch required for PA.
D7485 or CPT[2]	Surgical reduction of osseous tuberosity	No	Operative report required.
D7490 or CPT[2]	Radical resection of maxilla or mandible	No	Operative report required. Only allowable in hospital or ambulatory surgical center POS (place of service).
Surgical Incision			
D7510 or CPT[2]	Incision and drainage of abscess; intraoral soft tissue	No	Operative report required. Not to be used for periodontal abscess — use D9110.
D7511 or CPT[2]	Incision and drainage of abscess — intraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	No	Operative report required. Not to be used for periodontal abscess — use D9110.
D7520 or CPT[2]	extraoral soft tissue	No	Operative report required.
D7521 or CPT[2]	Incision and drainage of abscess — extraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	No	Operative report required.
D7530 or CPT[2]	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	No	Not allowed for removal of root fragments and bone spicules. (Use D7250 instead.) Operative report required.
D7540 or CPT[2]	Removal of reaction producing foreign bodies, musculoskeletal system	No	Not allowed for removal of root fragments and bone spicules. (Use D7250 instead.) Operative report required.
D7550 or CPT[2]	Partial ostectomy/sequestrectomy for removal of non-vital bone	No	Operative report required.
D7560 or CPT[2]	Maxillary sinusotomy for removal of tooth fragment or foreign body	No	Operative report required.
Treatment of Fractures — Simple			
D7610 or CPT[2]	Maxilla; open reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7620 or CPT[2]	closed reduction (teeth immobilized, if present)	No	Operative report required.
D7630 or CPT[2]	Mandible; open reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7640 or CPT[2]	closed reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS.

			Operative report required.
D7650 or CPT[2]	Malar and/or zygomatic arch; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7660 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7670 or CPT[2]	Alveolus closed reduction, may include stabilization of teeth	No	Operative report required.
D7671 or CPT[2]	Alveolus — open reduction, may include stabilization of teeth	No	Operative report required.
D7680 or CPT[2]	Facial bones — complicated reduction with fixation and multiple surgical approaches	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
Treatment of Fractures — Compound			
D7710 or CPT[2]	Maxilla; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7720 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7730 or CPT[2]	Mandible; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7740 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7750 or CPT[2]	Malar and/or zygomatic arch; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7760 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7770 or CPT[2]	Alveolus — open reduction stabilization of teeth	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7771 or CPT[2]	Alveolus — closed reduction stabilization of teeth	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7780 or CPT[2]	Facial bones — complicated reduction with fixation and multiple surgical approaches	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions			
D7810 or CPT[2]	Open reduction of dislocation	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7820 or	Closed reduction of dislocation	No	Once per DOS.[3]

CPT[2]			Operative report required.
D7830 or CPT[2]	Manipulation under anesthesia	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7840 or CPT[2]	Condylectomy	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7850 or CPT[2]	Surgical discectomy, with/without implant	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7860 or CPT[2]	Arthrotomy	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7871 or CPT[2]	Non-arthroscopic lysis and lavage	Yes	Allowable only once per side (right and left) per three years.
D7899	Unspecified TMD therapy, by report	Yes	Use this code for billing TMJ (temporomandibular joint) assistant surgeon. Procedure must be included in PA request for the surgery itself. Only allowable in hospital or ambulatory surgical center POS.
Repair of Traumatic Wounds			
D7910 or CPT[2]	Suture of recent small wounds up to 5 cm	No	*Emergency only*[1] — operative report required. Once per DOS.[3]
Complicated Suturing (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)			
D7911 or CPT[2]	Complicated suture — up to 5 cm	No	Covered for *trauma (emergency) situations only*.[1] Once per DOS.[3] Operative report required.
D7912 or CPT[2]	greater than 5 cm	No	Covered for *trauma (emergency) situations only*.[1] Once per DOS.[3] Operative report required.
Other Repair Procedures			
D7940 or CPT[2]	Osteoplasty — for orthognathic deformities	Yes	HealthCheck referral is required. Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required. Allowable age less than 21.
D7950 or CPT[2]	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones — autogeneous or nonautogeneous, by report	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7951	Sinus augmentation with bone or bone substitutes	No	
D7960 or CPT[2]	Frenulectomy (frenectomy or frenotomy) — separate procedure	Yes	HealthCheck referral is required. No operative report required. Allowable age less than 21.

D7970 or CPT[2]	Excision of hyperplastic tissue per arch	Yes	No operative report required.
D7972 or CPT[2]	Surgical reduction of fibrous tuberosity	No	Operative report required.
D7980 or CPT[2]	Sialolithotomy	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7991 or CPT[2]	Coronoidectomy	Yes	Only allowable in hospital or ambulatory surgical center POS. No operative report required.
D7997 or CPT[2]	Appliance removal (not by dentist who placed appliance), includes removal of archbar	No	Operative report required.
D7999 or CPT[2]	Unspecified oral surgery procedure, by report	Yes	For medically necessary oral and maxillofacial procedures not included on these tables. Operative report required.

[1] Retain records in member files regarding nature of emergency.
[2] Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists and who choose CPT billing must use a CPT code to bill for this procedure. Refer to the Dental Maximum Allowable Fee Schedule for allowable CPT procedure codes.
[3] Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

D8000-D8999 Orthodontics

Covered orthodontic services are identified by the allowable CDT procedure codes listed in the following table. Medicaid reimbursement is allowable only for services that meet all program requirements. This includes documenting the medical necessity of services in the member's medical record.

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Limited Orthodontic Treatment			
D8010	Limited orthodontic treatment; of the primary dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8020	of the transitional dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8030	of the adolescent dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8040	of the adult dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
Interceptive Orthodontic Treatment			
D8050	Interceptive orthodontic treatment; of the primary dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8060	of the transitional dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
Comprehensive Orthodontic Treatment			
D8070	Comprehensive orthodontic treatment; of the transitional dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8080	of the adolescent dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8090	of the adult dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
Minor Treatment to Control Harmful Habits			

D8210	Removable appliance therapy	Yes	HealthCheck referral is required. Allowable age less than 21.
D8220	Fixed appliance therapy	Yes	HealthCheck referral is required. Allowable age less than 21.
Other Orthodontic Services			
D8660	Pre-orthodontic treatment visit	No	HealthCheck referral is required. Allowable age less than 21. Includes exam, diagnostic tests and consult.
D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	HealthCheck referral is required. Allowable age less than 21. Used for monthly adjustments.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer[s])	Yes	HealthCheck referral is required. Allowable age less than 21.
D8692	Replacement of lost or broken retainer	Yes	HealthCheck referral is required. Allowable age less than 21.
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	No	

Topic #2820

Tooth Numbers and Letters

BadgerCare Plus recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" through "32" for permanent teeth.

BadgerCare Plus also recognizes supernumerary teeth that cannot be classified under "A" through "T" or "1" through "32." For primary teeth, an "S" will be placed after the applicable tooth letter (values "AS" through "TS"). For permanent teeth, enter the sum of the value of the tooth number closest to the supernumerary tooth and 50. For example, if the tooth number closest to the supernumerary tooth has a value of 12, the provider will indicate supernumerary with the number 62 (12 + 50 = 62).

Topic #2866

Tooth Surfaces

BadgerCare Plus has identified BadgerCare Plus allowable tooth surface codes for dental services providers.

Anterior Teeth (Centrals, Laterals, Cuspids)

Surface	Code
Mesial	M
Facial	F
Incisal	I
Lingual	L
Distal	D
Gingival	G

Posterior Teeth (Pre-molars/Bicuspids, Molars)

Surface	Code
Mesial	M
Bucal	B
Occlusal	O
Lingual	L
Distal	D
Gingival	G

BadgerCare Plus reimburses *only* per unique surface regardless of location. When gingival (G) is listed with a second surface, such as BG, BFG, DG, FG, LG, MG, the combination is considered a single surface. Also, "FB" is considered one surface since the two letters describe the same tooth surface.

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

- Include only relevant documentation.
- Include all required clinical/supporting documentation.

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Covered Services and Requirements

Topic #4379

Benchmark Plan Covered Dental Services

Certain dental services are covered under the BadgerCare Plus Benchmark Plan only for the following members:

- Children under 19 years of age.
- Pregnant women.

Coverage under the Benchmark Plan is limited to specific services within the following categories:

- Diagnostic.
- Preventive.
- Simple restorative.
- Periodontics.
- Surgical procedures.

Temporomandibular Joint Dysfunctions

Diagnosis and treatment for TMJ (temporomandibular joint) dysfunctions covered under the Benchmark Plan are the same as they are under the BadgerCare Plus Standard Plan.

Traumatic Injury

Services provided by a dentist for traumatic injuries may be covered — subject to review by a dental consultant — under the Benchmark Plan for children under 19 years of age and for pregnant women. Claims submitted for services that are not listed as covered Benchmark Plan procedure codes will be reviewed for reimbursement as a traumatic injury-related service.

Service Limitations

Total benefits are limited for all Benchmark Plan members to $750.00 per enrollment year, based on the amount paid by the Benchmark Plan. Any services provided in an enrollment year after the $750.00 annual limit is met are considered noncovered services.

Topic #5497

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 (Department of Health Services) 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.

Topic #5617

Core Plan and Basic Plan Covered Dental Services

Non-emergency dental services are not covered under the BadgerCare Plus Core Plan and BadgerCare Plus Basic Plan. However, a limited number of dental services are covered under the Core Plan and Basic Plan when performed as an emergency service only.

By indicating designated CDT (Current Dental Terminology) procedure codes on claims for Core Plan or Basic Plan services, emergency service is implied. Providers should retain documentation of emergency services in case of a future audit.

Under the Core Plan, covered emergency dental services billed with CDT codes are reimbursed fee-for-service, not by the BadgerCare Plus HMO, regardless of place of service.

Topic #44

Definition of Covered Services

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

Topic #85

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 (prior authorization) 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.

Topic #2804

Emergency Dental Services

Emergency dental care is immediate service that must be provided to relieve the member from pain, an acute infection, swelling, trismus, fever, or trauma.

PA (prior authorization) is not required in emergency situations.

PA for general anesthesia and intravenous sedation is waived. These procedures are the only procedures in which PA is waived in an emergency.

ForwardHealth has identified certain services that are allowable *only* in emergency situations in the following categories:

- Diagnostic procedures.
- Oral and maxillofacial surgeries.
- Adjunctive general services.

Providers must retain documentation in the member's records regarding the nature of the emergency.

Emergency services are exempt from copayment.

Traumatic Loss of Teeth for Children Under Age 21

When a child experiences a traumatic loss of an anterior tooth or teeth (tooth numbers 6-11, 22-27), removable prostheses may be provided by backdating a PA request.

Topic #2845

HealthCheck

HealthCheck is Wisconsin Medicaid's federally-mandated program known nationally as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). Through HealthCheck, children receive preventive medical check-ups, immunizations, and referrals.

To be eligible for a HealthCheck referral, a member must:

- Have a current Medicaid identification card.
- Be under 21 years of age.

When a member is enrolled in a contracted managed care program, only the managed care program or its affiliated providers may provide the HealthCheck screening for that member.

Dentists can encourage members to obtain their HealthCheck screenings before their dental visits. This is particularly helpful when members have a medical need for orthodontia.

All allowable services resulting from a HealthCheck screening must be provided within one year of the screening date. When providing a service that requires a HealthCheck screening, dentists are required to maintain documentation, (e.g., a photocopy of the member's current HealthCheck card), that a HealthCheck screening has occurred in the past year. The HealthCheck provider signature is required on the documentation. No additional statement from the HealthCheck provider is needed. This evidence must be submitted with PA (prior authorization) requests, but is not required when submitting claims. A new HealthCheck screening must be performed if more than one year has passed since the previous screening.

A dentist should refer the member to the HealthCheck Hotline telephone number at (800) 722-2295. Members may also obtain information from the HealthCheck Web site.

Topic #84

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.

Topic #86

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 (prior authorization) was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

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

Topic #5677

Not Otherwise Classified Procedure Codes

Providers who indicate procedure codes such as J3490 (Unclassified drugs), J3590 (Unclassified biologics), or J9999 (Not otherwise classified, antineoplastic drugs) on claims for NOC (not otherwise classified) drugs must also indicate the following on the claim:

- The NDC (National Drug Code) of the drug dispensed.
- The name of the drug.
- The quantity billed.
- The unit of issue (i.e., F2, gr, me, ml, un).

If this information is not included on the claim or if there is a more specific HCPCS (Healthcare Common Procedure Coding System) procedure code for the drug, the claim will be denied. Compound drugs that do not include a drug approved by the FDA (Food and Drug Administration) will be denied.

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

Topic #2847

Occupational Illness, Injury, or Accident

All claims submitted which related to an occupational illness, injury, or accident must be clearly identified and explained.

Topic #66

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 (prior authorization), claims submission, prescription, and documentation requirements.

Topic #5697

Provider-Administered Drugs

A provider-administered drug is either an oral, injectible, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant) or incidental to a physician service. This includes, but is not limited to, all "J" codes and drug-related "Q" codes.

Providers may refer to the maximum allowable fee schedules for the most current HCPCS (Healthcare Common Procedure Coding System) and CPT (Current Procedural Terminology) procedure codes for provider-administered drugs and reimbursement rates.

For members enrolled in BadgerCare Plus HMOs (health maintenance organizations), Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO (managed care organization), reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

All fee-for-service policies and procedures related to provider-administered drugs, including copayment, cost sharing, diagnosis restriction, PA (prior authorization), and pricing policies, apply to claims submitted to fee-for-service for members enrolled in an MCO.

Provider-administered drugs and related services for members enrolled in the PACE (Program of All-Inclusive Care for the Elderly) and the Family Care Partnership are provided and reimbursed by the special managed care program.

Obtaining Provider-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. If a member is given a drug to be administered by the provider for which storage, handling, and care instructions apply and the instructions are followed incorrectly, the dose may be ineffective. Prescribers may obtain a provider-administered drug from the member's pharmacy provider if the drug is transported directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Topic #7897

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 (prior authorization) 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.

Topic #824

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus and Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

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

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of 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 (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration.
- Services provided by a provider who fails or refuses to meet and maintain any of the 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.

Diagnostic Services

Topic #2825

An Overview

Medicaid-allowable dental diagnostic services include the following:

- Clinical oral evaluations.
- Radiographs/diagnostic imaging.
- Tests and examinations.

These services allow dental providers to do the following:

- Assess oral health.
- Diagnose oral pathology.
- Develop an adequate treatment plan for the member's oral health.

Topic #2886

Emergency Exams

BadgerCare Plus covers limited, problem-focused oral evaluations (D0140) once per six months per member.

Topic #2869

Oral Evaluations

Dentists are required to document and maintain oral evaluation information in the same manner for BadgerCare Plus members as they do for other patients. BadgerCare Plus regulations and accepted standards of dental care require documentation of the following evaluations:

- Periodic evaluations.
- Limited oral evaluation — problem focused.
- Comprehensive oral evaluations.
- Detailed and extensive oral evaluations — problem focused.
- Re-evaluation — limited — problem focused.

Dentists are required to submit claims for the oral evaluation procedure appropriate to the level of service provided and include documentation supporting the medical necessity of the services in the member's record.

Children ages 13-20 may receive up to two additional oral evaluations per year through HealthCheck with PA (prior authorization). Providers should submit PA requests and claims with procedure code D0999 for these services. A copy of a valid HealthCheck is also required when submitting the PA request.

Oral Evaluations Performed in Nursing Homes or for Children

To provide greater flexibility in scheduling oral evaluations for members residing in a nursing home or for children, the time period between oral evaluations may be as few as 330 days for adults in nursing homes and 160 days for children.

Topic #2870

Radiographs

ForwardHealth coverage of radiographs includes reimbursement for exposure, developing, mounting, and interpretation of the radiograph.

An intraoral complete series may include either a periapical series plus bitewings or a panorex plus bitewings. Individual panoramic radiographs are covered when another radiograph is insufficient for proper diagnosis.

Full Mouth Radiographs

Dentists may obtain PA (prior authorization) for additional full mouth (intraoral complete series) radiographs or panoramic films in cases of trauma or other unusual medical or dental clinical histories, such as cancer or rampant decay.

Panoramic Films (D0330)

Coverage of panoramic films is limited to once per member per DOS (date of service), and should be taken *only* when another type of radiograph is insufficient for diagnosis. Documentation to support the medical necessity of this service must be included in the member's record.

When a panoramic film *and* bitewings are taken on the same DOS, claims should be submitted with procedure code D0210 (Intraoral; complete series [including bitewings]) only.

Cephalormetric Films and Pre-Orthodontic Visits (D0340, D8660)

Cephalormetric films and pre-orthodontic visit services are limited to members with an orthodontic diagnosis only. Providers may submit claims for these services before submitting a PA request for orthodontia.

Oral/Facial Photographic Images (D0350)

Oral/facial photographic images may be used as a diagnostic tool for oral surgery and orthodontia services only and may be submitted as supporting clinical documentation with a PA request.

Mounting Radiographs for Prior Authorization

When *four or more* periapical X-rays, four bitewing X-rays, or when a full mouth X-ray must be submitted to BadgerCare Plus to substantiate a PA request, providers should mount the X-rays to allow for proper identification and to speed the review process.

Providers are required to do the following when sending in four or more periapical X-rays, four bitewing X-rays, or a full mouth series:

- Mount the X-rays.
- Label the X-rays (left or right).
- Include the date the X-rays were taken.
- Include the member's name and identification number.
- Include the provider's name and provider number.

When sending in three or fewer periapical or bitewing X-rays:

- Label the X-rays (left or right).
- Include the date the X-rays were taken.
- Include the member's name and identification number.
- Include the provider's name and provider number.
- Place X-rays in an envelope.
- Staple X-ray envelope to designated portion of PA form that states, "Staple X-ray envelope here."

Submitting Claims for Radiographs

Radiographs provided to a member on the same DOS must be submitted on the same claim form. Wisconsin Medicaid denies reimbursement for services performed on the same DOS but submitted on separate claim forms.

Endodontics

Topic #2867

An Overview

BadgerCare Plus coverage of endodontic services includes the following services:

- Pulpotomy.
- Endodontic therapy.
- Apexification.
- Apicoectomy/periradicular services.

Endontic sevices are covered only under the BadgerCare Plus Standard Plan and Medicaid and are not covered under the BadgerCare Plus Benchmark Plan.

BadgerCare Plus has identified allowable endodontic procedure codes.

Topic #2881

Anterior, Bicuspid, and Molar Root Canal Therapy

Root canal therapy should only be provided when there is a strong likelihood that the treatment will be successful and definitive (i.e., that it will not later result in extraction). To receive Medicaid reimbursement for root canal therapy, the member's record must include clinical documentation of *all* the following:

- Evidence of good periodontal health (AAP (American Academy of Periodontology) periodontal classification of Type I or II).
- Evidence visible on radiographs that at least 50 percent of the clinical crown is intact.
- A treatment plan that identifies no more than three teeth for root canal therapy, including molars. Molar root canals (D3330) for members ages 21 and older and treatment plans involving root canal therapy on four or more teeth require PA (prior authorization).

Anterior, bicuspid, and molar root canals (D3310, D3320, and D3330) are not reimbursable if any of the following are true:

- The member has fewer than two posterior teeth in occlusion per quadrant.
- The member is missing six or more teeth in the arch where the root canal is to be performed, including third molars.
- The member is missing one or more anterior teeth in the arch where the root canal is to be performed.

If the member has one of the previously listed conditions, he or she may qualify for a partial denture and the provider should request PA for the partial denture service.

Topic #2882

Apicoectomy and Retrograde Fillings

Apicoectomy and retrograde fillings (D3410, D3430) are only allowable for permanent anterior teeth (6-11, 22-27, and corresponding supernumerary teeth). Providers are required to retain documentation, such as radiographs, supporting the medical

necessity of these services. These services are not payable with root canal therapy on some DOS (dates of service). Examples of medical necessity include, but are not limited to, the following:

- Fractured root tip.
- Periapical pathology not resolved by conventional root canal therapy.
- Broken root canal file.
- Symptomatic files.

Topic #2879

Open Tooth for Drainage

Emergency treatment for members needing root canal therapy may be provided to allow the dentist to relieve pain and/or extirpate the tooth in anticipation of proceeding with a root canal. Providers should submit claims for this procedure with CDT (Current Dental Terminology) code D9110 (Palliative [emergency] treatment of dental pain — minor procedure).

Topic #2880

Referrals to Endodontists

General dentists should not refer BadgerCare Plus members to endodontists unless the member has a restorative dentist to provide restoration of the teeth.

Dental providers referring a member to an endodontist for root canal procedures that require PA (prior authorization), should complete the appropriate sections of the PA/DA1 (Prior Authorization Dental Attachment 1, F-11010 (10/08)) and send it to the endodontist with the referral.

When referring BadgerCare Plus members to endodontists, providers must supply the endodontist with the following information:

- A minimum of two bitewing X-rays.
- An oral charting of missing teeth.
- A treatment plan including plan for involved tooth.
- The member's oral hygiene status.
- Attendance information.
- The date and reason for any extractions performed within the past three years.

Topic #2878

Root Canal Therapy

Dental providers must adhere to the following guidelines when performing endodontic services:

- The standard of acceptability employed by BadgerCare Plus for endodontic procedures requires that the canal(s) be completely filled apically and laterally.
- Root canal therapy for permanent teeth includes the following:
    1. Diagnosis.
    2. Extirpation.
    3. Treatment.
    4. Progress radiographs.
    5. Filling and obliteration of root canals.

6. Temporary fillings.

When a root canal filling does not meet its treatment standards, BadgerCare Plus may do the following:

- Require the procedure to be redone with no additional Wisconsin Medicaid reimbursement or cost to the member.
- Recoup any reimbursement already made after the ForwardHealth dental consultant reviews the circumstances.

Radiographs

A post treatment radiograph is required for all root canal therapy and may be reimbursed separately.

Interrupted Root Canal Therapy

If root canal therapy has begun and the member under treatment becomes ineligible for BadgerCare Plus or fails to return for subsequent visits, providers may submit claims for opening a tooth for drainage with CDT (Current Dental Terminology) procedure codes D9110 and D2940 (Sedative filling) to receive reimbursement for the services provided.

HealthCheck "Other Services"

Topic #2842

ForwardHealth covers orthodontia and some other dental services only if the child has received a HealthCheck screening within the last 365 days. ForwardHealth has identified dental services that require a HealthCheck referral.

This information only applies to eligible members under BadgerCare Plus Standard Plan and Medicaid.

As a result of the federal Omnibus Budget Reconciliation Act of 1989 (OBRA), Wisconsin Medicaid considers PA (prior authorization) requests for coverage of medically necessary dental services that are not specifically listed as covered services, or that are listed as nonreimbursable services, when all of the following conditions are met:

- The provider verifies that a comprehensive HealthCheck referral has been performed in the past year through a signed written document from the HealthCheck provider.
- The service is allowed under the Social Security Act as a "medical service."
- The service is "medically necessary" and "reasonable" to correct or ameliorate a condition or defect which is discovered during a HealthCheck referral.
- The service is noncovered under BadgerCare Plus.
- A service currently covered by BadgerCare Plus is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" require PA.

Topic #22

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). 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 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.

Topic #1

Prior Authorization

To receive PA (prior authorization) 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 (Prior Authorization Request Form, F-11018 (10/08)) (or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (10/08)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services 1, F-11020 (10/08))).
  - 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.

Topic #41

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 (prior authorization) 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.

ForwardHealth has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as limitations are reasonable and maintain the preventive intent of the HealthCheck program.

Maxillofacial Prosthetics

Topic #2894

An Overview

Wisconsin Medicaid reimburses dental providers for allowable maxillofacial prosthetics identified by ForwardHealth.

This information only applies to BadgerCare Plus Standard Plan and Medicaid.

Obturators (D5932) for cleft palate and palatal lifts prostheses (D5955) are allowed once per six months. This frequency limitation may be exceeded in exceptional circumstances with written justification on a PA (prior authorization) request. Providers are required to retain documentation of medical necessity of these procedures.

PA requests for maxillofacial prostheses should also include a request for a complete or removable partial denture when clinically appropriate. PA requests for unspecified maxillofacial prostheses must include laboratory bills and are approved based on documentation of medical necessity and appropriateness on a case-by-case basis.

Noncovered Services

Topic #9337

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.
- CRS (Community Recovery Services).
- 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, PDN (private duty nursing)).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV (specialized medical vehicle)).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC (prenatal care coordination).
- Provider-administered drugs.
- Routine vision examinations billed with CPT (Current Procedural Terminology) codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS (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.

Topic #68

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.

Topic #104

Member Payment for Noncovered Services

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

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for certain noncovered services or activities provided in connection with covered services, including 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 (Centers for Medicare and Medicaid Services) does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- Encourage the member to call for NEMT (non-emergency medical transportation) services. Most members may receive NEMT services through LogsitiCare. Refer to the NEMT service area for more information.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation 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

Oral and Maxillofacial Surgery

Topic #2924

An Overview

BadgerCare Plus's coverage of oral and maxillofacial surgical services is limited to services provided due to trauma or congenital malformations, such as clefts, or the removal or pathologic, painful, or non-restorable teeth. Corrective congenital surgery and orthognathic surgery are limited to specific cases due to severe handicapping malocclusions.

Not all oral and maxillofacial surgery services are covered under the Benchmark Plan; therefore, information within this section may not apply to the Benchmark Plan.

Wisconsin Medicaid reimburses for the following oral and maxillofacial surgery services:

- Extractions.
- Surgical extractions.
- Alveoloplasty.
- Surgical excision of soft tissue lesions.
- Surgical excision of intra-osseous lesions.
- Excision of bone tissue.
- Surgical incision.
- Treatment of simple and compound fractures.
- Reduction of dislocation and management of other temporomandibular joint dysfunctions.
- Repair of traumatic wounds.
- Complicated suturing.
- Other surgical and repair procedures.

Providers are required to obtain PA (prior authorization) for certain specified oral and maxillofacial surgery services before delivery of the service, unless the service is performed on an emergency basis. BadgerCare Plus may request a diagnostic cast or oral/facial photographic images to aid in evaluating any PA request.

BadgerCare Plus has identified allowable oral and maxillofacial surgery procedure codes.

Topic #2925

Assistant Surgeon

An assisting surgeon is allowed for some allowable complex surgery procedures.

When CPT (Current Procedural Terminology) billing providers request reimbursement for an assisting surgeon, indicate modifier "80" (Assistant surgeon) in the appropriate element on the claim. If a procedure requires PA (prior authorization) and an assistant surgeon will be involved with performing the procedure(s), providers are required to request PA for both on the same PA request.

ADA (American Dental Association) billing providers are required to request PA for assisting surgeons. Providers should use D7899 for an assistant surgeon for TMJ (temporomandibular joint) services and D7999 for all other types of assisting surgeon services.

Topic #2926

Claims Submission Options

Dentists are assigned a procedure coding system to use for submitting claims for oral surgery services based on their speciality.

Assignment of Oral Surgery Claims Submission Method

Assignment of a provider's oral surgery claims submission method depends on the dental specialty chosen during Medicaid certification. This assignment is necessary because it enables BadgerCare Plus to identify the oral surgery procedure codes a provider may use to ensure accurate reimbursement.

Identical Policies and Reimbursement for All Dentists

All dentists, regardless of specialty:

- Receive the same reimbursement for the same procedures.
- Have virtually the same program limitations, such as PA (prior authorization) requirements, for the same procedures.
- Submit claims for all other dental (nonsurgical) procedures using CDT (Current Dental Terminology) procedure codes and a few BadgerCare Plus HCPCS (Healthcare Common Procedure Coding System) procedure codes.
- Submit claims for all oral surgeries using the code system assigned at certification.
- Cannot temporarily alternate between coding systems, using different procedure codes on different days.
- Find that the CPT claims submission method requires fewer attachments and is easier to submit electronically.

Decreased Attachments and Claim Processing Time

The CPT coding system is more precise than the ADA coding system for describing the same oral surgery procedures. Therefore, most CPT codes do not require operative and pathology reports for manual pricing by Wisconsin Medicaid, as well as the additional time needed for processing manually priced claims. This facilitates electronic claims submission.

Topic #2927

Excision of Hyperplastic Tissue

For ForwardHealth coverage of PA (prior authorization) requests for the excision of hyperplastic tissue (per arch), the member must have an edentulous ridge, and have difficulty wearing a prosthesis. The member must have adequate healing after tooth extraction before requesting this service. The service includes all local anesthetic, suturing, postoperative care, and soft tissue conditioning of any appliances at the time of surgery.

Topic #2928

Limitations

Many oral surgeries are limited to once per day. This limitation may be exceeded if narrative on the claim form demonstrates the additional services were medically necessary.

Topic #2929

Osteoplasty/Osteotomy

Wisconsin Medicaid reimburses for osteoplasty/osteotomy for orthognathic deformities for only the most severe orthodontic skeletal malocclusion. PA (prior authorization) requests for correction of orthognathic deformities require a HealthCheck exam. Criteria for PA approval for osteoplasty or osteotomy includes one of the following, where the procedure is necessary to correct:

- The most severe cases of protruding or retruding mandible or maxillae where conventional orthodontics cannot provide a stable and acceptable outcome.
- The most severe cases of open bite where conventional orthodontics cannot provide a stable and acceptable outcome.
- A significant skeletal malocclusion where conventional orthodontics cannot provide a stable and acceptable outcome.
- Severe malocclusions caused by disease or injury where conventional orthodontics cannot provide a stable and acceptable outcome.

If the deformity has been caused by disease or injury, a physician's statement is required.

The criteria for PA approval includes a frenum which creates a central incisor diastema, ankyloglossia, periodontal defects, or is necessary to complete orthodontic services.

Topic #2930

Pre- and Post-Care Days

Reimbursement for procedures directly related to an oral surgery is incorporated into the reimbursement for the oral surgery procedure.

Palliative treatment, application of desensitizing medicaments, and other related procedures are not allowed at least three days before and 10 or more days after the surgery. Claims for other procedures *directly related* to the surgery must not be submitted separately, regardless of when the claim for the procedure is submitted.

If the procedure is *not directly related* to oral surgery, the limitation can be overridden with a narrative demonstrating that fact on the claim form. For example, a procedure may be performed on a separate section of the mouth than the oral surgery.

Topic #2932

Removal of Extosis Maxillae or Mandible

Criteria for PA (prior authorization) approval for the removal of extosis maxillae or mandible includes one of the following situations:

- The exostosis presents an undesirable undercut.
- The exostosis presents problems with insertion or stability of the prosthesis.
- The removal is medically necessary due to the presence of pain caused by the insertion or wearing of a removable prosthesis.

Topic #2931

Removal of a Foreign Body

PA (prior authorization) requests for removal of a foreign body must be accompanied by one periapical radiograph.

Topic #2933

Replantation and Splinting

BadgerCare Plus's coverage of the replantation and splinting of a traumatically avulsed or subluxated tooth:

- Includes the postoperative follow-up.
- Includes the removal of any splints and wires.
- Does not include any root canal therapy for the involved teeth.

Topic #2935

Surgical Exposure of Impacted or Unerupted Tooth

Reimbursement for the surgical exposure of an impacted or unerupted tooth for orthodontic reasons includes (with PA (prior authorization)) placement of any hooks, wires, pins, etc., to aid eruption through orthodontics. This service includes placement of any orthodontic appliance on the impacted tooth.

Include the following documentation with PA requests for this service:

- A HealthCheck exam (the HealthCheck provider signature is required).
- A periapical radiograph of the tooth.

Topic #2934

Surgical Exposure of a Tooth to Aid Eruption

For surgical exposure of a tooth to aid eruption, the tooth must be impacted by an adjacent tooth, and not close to natural eruption. This service can be requested for primary and permanent teeth.

This service does not include placement of any hooks, wires, pins, etc., to aid eruption through orthodontics.

Include the following documentation with PA (prior authorization) requests for this service:

- A HealthCheck exam (the HealthCheck provider signature is required).
- A periapical radiograph of the tooth.

Topic #2936

Surgical Extraction of a Tooth

Wisconsin Medicaid's reimbursement for surgical extraction of a tooth is limited to when an extraction is necessary for the following reasons:

- An emergency, which is a situation when an immediate service must be provided to relieve the member from pain, an acute infection, swelling, fever, or trauma.
- Orthodontia (for children up to age 21). In this case, PA (prior authorization) should be requested for the surgical extraction of a tooth in a non-emergency situation.

If during the routine extraction of any tooth the extraction unexpectedly becomes a surgical extraction, the surgical extraction is considered a dental emergency. The provider should indicate that the procedure was an emergency when submitting a claim to

ForwardHealth. Providers should also retain documentation of the circumstances of the procedure in the member's records.

Topic #2937

Suturing

Wisconsin Medicaid reimburses providers for suturing only when it is provided as a result of trauma. Suturing is not separately reimbursable when it is part of a surgical procedure, as suturing is included in the surgical procedure and fee.

When submitting claims for suturing, include an operative report describing the procedure, complexity of closure, location of laceration, and length of laceration(s) repaired.

Topic #2938

Temporomandibular Joint Surgery

The TMJ (temporomandibular joint) office visit requires detailed and extensive examination and documentation of the member's TMJ dysfunction.

A TMJ office visit consists of:

- A comprehensive history.
- Clinical examination.
- Diagnosis.
- Treatment planning.

Initial Treatment

The initial treatment of a TMJ dysfunction must consist of nonsurgical treatments which include:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

Nonsurgical TMJ treatments are not covered.

Prior Authorization

Providers are required to include appropriate current clinical physical and dental information about the member on the PA request to enable ForwardHealth to determine whether the surgery is medically necessary. Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

TMJ Surgery Procedures and Managed Care Programs

State-contracted MCOs (managed care organizations) may designate the facility at which the TMJ surgery is performed. The MCO is responsible for paying the cost of the surgery and all related services (e.g., hospitalization and anesthesiology).

Wisconsin Medicaid does not reimburse for a TMJ surgery performed by a dentist on a fee-for-service basis when provided to a member enrolled in an MCO that covers dentistry. Therefore, to obtain reimbursement, dentists must participate in or obtain a referral from the member's MCO since the MCO is responsible for paying the cost of all services. Failing to obtain an MCO referral may result in a denial of payment for services by the MCO.

If the MCO does not cover dental services, the dentist may submit a PA request to ForwardHealth and, if approved, the dental surgeon is reimbursed for the evaluation on a fee-for-service basis.

- ForwardHealth has identified MCOs and services for which dental providers may request fee-for-service reimbursement.
- If PA is obtained, the MCO is responsible for paying the cost of all related medical and hospital services and may therefore designate the facility at which the surgery is performed.
- The dentist must work closely with the MCO to assure continuity of coverage.

Orthodontics

Topic #2905

An Overview

Wisconsin Medicaid reimburses providers for orthodontic services including the following.

- Limited orthodontic treatment.
- Interceptive orthodontic treatment.
- Comprehensive orthodontic treatment.
- Minor treatment to control harmful habits.
- Other orthodontic services.

This information applies to BadgerCare Plus Standard Plan and Medicaid only.

HealthCheck Requirement

Orthodontia treatment is available only after the member has received a HealthCheck exam and is not available to adults over age 20. A well child exam, sports physical, or presurgical physical will not be accepted as a HealthCheck exam.

Member Eligibility for Completion of Orthodontic Treatment

Regardless of member subsequent eligibility, all approved orthodontic services, once started (bands, brackets, or appliances placed during a period of eligibility) are reimbursed to completion of the approved services performed by a certified provider.

If an orthodontia member becomes BadgerCare Plus-eligible in mid-treatment, BadgerCare Plus will approve a PA (prior authorization) request for continued services if all PA criteria are met.

Prior Authorization Requirements

All orthodontic services require PA and a HealthCheck referral.

Pre-orthodontic treatment visits (D8660) include an examination, consultation, and the obtaining of diagnostic casts. This service is limited to members with an orthodontic diagnosis only. Providers may submit claims for these services before submitting a PA request for orthodontia.

Panoramic x-ray (D0330), cephalometric x-ray (D0340), and oral/facial photographic images (D0350) for members with an orthodontic diagnosis do not require PA. Claims for these services may be submitted before submission of a PA request for orthodontia.

Documentation

The following documentation must be submitted with all PA requests for orthodontic services:

- Orthodontic records of the examination, consultation, and diagnostic casts. Casts must be securely packed, clearly labeled to identify the provider and the member, and must include a bite registration.
- A completed PA/DRF (Prior Authorization Dental Request Form, F-11035 (10/08)) and PA/DA2 (Prior Authorization/Dental Attachment 2, F-11014 (10/08)).

- Evidence that a HealthCheck exam has occurred within the past year.
- A specific orthodontic treatment plan that addresses appliance(s) to be used during the course of treatment.

Topic #2906

Fixed or Removable Appliances

Limited Orthodontic Treatment

Limited treatment services are for correction of a minor malocclusion in which one to four teeth are involved. It is considered especially for children under the age of 12 in the transitional dentition stage of development. Services may be used to correct anterior crossbites, ectopic eruption of permanent first molars, and bite plates.

Interceptive Orthodontic Treatment

Interceptive orthodontic treatment is for the correction of a minor malocclusion in which one to four teeth are involved, and is considered especially for children under the age of 12 in the transitional dentition stage of development. The correction of posterior cross bites, orthopedic orthodontics, and 2 x 4 interceptive procedures are allowed services under this procedure. Interceptive procedures are not inclusive of comprehensive orthodontic treatment of this malocclusion. Interceptive orthodontic treatment of adolescent or adult dentition is not a covered service.

Minor Treatment to Control Harmful Habits

Correction of harmful habits such as thumb, finger, tongue, or lip sucking is considered especially for children under the age of 12 in the transitional dentition stage of development. Fixed appliances only are encouraged.

Topic #2907

Initial Treatment and Billing Date

When billing for the initial orthodontic banding service, the date used is the day the treatment started. This is defined as the date when the bands, brackets, or appliances are placed in the member's mouth. The member must be BadgerCare Plus eligible on this DOS (date of service).

Topic #2908

Retainers

Retainers can be authorized for limited, interceptive, or comprehensive orthodontic services requested. If retainers are separately identified on an approved PA (prior authorization) for orthodontic service, they may be separately reimbursed. However, when submitting the PA request, the provider may include the placement, fees, and follow-up for retainers in the initial fee and monthly adjustments. In this case, a separate request for retainers will not be granted. Using either way of billing, the maximum fee for orthodontic treatment will be the same.

Lost or Damaged Retainers

In cases of lost or damaged retainers, the provider should submit a new PA request for a new retainer. New orthodontic records do not need to be submitted with the new PA. However, multiple lost retainers (due to member negligence) will not be replaced. HealthCheck is not required. The provider is required to indicate the date the initial retainer was placed. The member and/or family

are required to indicate when and how the retainer was lost and present a plan to prevent future loss.

Topic #2909

Severe Malocclusion

The following criteria are considered when reviewing PA (prior authorization) requests for orthodontia:

- A severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
- In extenuating circumstances, the dental consultant may, after comprehensive review of the case, determine that a severe handicapping malocclusion does exist, and approve the orthodontia treatment even though the Salzmann score is less than 30.
- Transfer cases from out-of-state or within state must fulfill BadgerCare Plus criteria of age and Salzmann Index at time of initial treatment (banding).
- Certain cases of minor treatment (1-4 teeth) can be approved for limited or interceptive orthodontic treatment using either fixed or removable appliances.
- If the request for orthodontic services is the result of a personality or psychological problem or condition and a member does not meet the criteria listed above, then a referral from a mental health professional is required.

Orthodontic treatment is *not* authorized for cosmetic reasons. Transfer cases from one certified provider to another certificed provider are reimbursed at the maximum fee authorized minus the fees reimbursed to the original provider.

Topic #2910

Terminated Treatment

If any orthodontic treatment is terminated prior to completion, the provider is required to notify BadgerCare Plus in writing within 30 days of termination. The notification must include the reason(s) for termination and a copy of the treatment progress notes.

Periodontics

Topic #2868

An Overview

Wisconsin Medicaid reimburses dental providers for the following allowable periodontic services identified by BadgerCare Plus:

- Surgical services.
- Nonsurgical services.
- Other periodontic services.

All services performed on the same DOS (date of service) must be submitted on the same claim form. Wisconsin Medicaid denies reimbursement for services performed on the same DOS submitted on separate claim forms.

When submitting PA (prior authorization) requests for periodontic services, ForwardHealth requires the following information:

- Complete periodontal charting of oral cavity.
- Significant medical and dental history.
- Comprehensive treatment plan for periodontal disease, including treatment, surgery, and postoperative care, including additional prophylaxes as needed for permanently disabled recipients.

Quadrants/Area of Oral Cavity

Effective for prior authorizations received on and after September 1, 2006, BadgerCare Plus will define gingivectomy/gingivoplasty and periodontal scaling and root planing according to CDT 2007 terminology of four or more contiguous teeth or one to three contiguous teeth.

Four quadrants per day are allowed in inpatient and outpatient hospital and ambulatory surgical center settings. In other settings, only two quadrants are allowed in a day. However, if the member has difficulty traveling to dental appointments or if medical or other reasons are indicated on the PA request, then PA for scaling and root planing may be approved up to four quadrants per day, per member.

Dentists are required to submit PA requests and claims for certain periodontic services with the appropriate area of oral cavity code for each quadrant requested. Each quadrant must be requested on a separate detail line.

Topic #2883

Full-Mouth Debridement

Full-mouth debridement (D4355) is allowable only once per three years for members ages 13 and older and is not reimbursable on the same DOS (date of service) as prophylaxis procedures. If full-mouth debridement is completed in more than one appointment, the service should be billed on the date of completion. Excess calculus must be evident on x-rays and documented in the member's medical record.

No other periodontal therapy (D4341, D4342, D4910) will be authorized within three months after full-mouth debridement.

Preventive Services

Topic #2864

An Overview

BadgerCare Plus allowable dental preventive services include the following:

- Dental prophylaxes.
- Topical flouride treatment.
- Space maintenance.
- Other preventive services.

Topic #2872

Fluoride Treatment

Topical application of fluoride without prophylaxis for members ages 0-12 (D1203) is limited to two applications per 12-month period.

Topical application of fluoride without prophylaxis (D1204) is allowable for members ages 13 and older.

Topical fluoride varnish (D1206) is allowable for moderate to high caries risk members. Providers are required to retain documentation of caries risk in the member's medical record.

Topic #2871

Prophylaxes

Preventive services include routine prophylaxes (which includes scaling and polishing) for adults and children.

Prophylaxis Services Performed in a Nursing Home or for Children

To provide greater flexibility in scheduling prophylaxis services in a nursing home or for children, the time period between services may be as few as 330 days for adults and 160 days for children.

Prophylaxis (D1110, D1120)

Prophylaxis services are limited to one per six-month period for members through age 20 and one per 12-month period for members ages 21 and older.

Members With Disabilities that Impair Their Ability to Maintain Oral Hygiene

For members with a permanent physical or developmental disability that impairs their ability to maintain oral hygiene, up to four prophylaxis services may be provided per 12-month period. Providers are required to retain documentation of the member's

disability in his or her record.

Topic #2873

Sealants

Sealants are allowable for members up to age 20. Providers are required to document the medical necessity of the sealants (e.g., due to congenital malformation) when sealants are placed on teeth other than primary or secondary molars.

Topic #2874

Space Maintenance

Wisconsin Medicaid reimburses providers for space maintenance therapy. This service includes coverage of missing anterior teeth, bilateral missing posterior teeth, and unilateral missing posterior teeth.

A space maintainer which includes a stainless steel crown (loop or distal shoe types) is reimbursed as a spacer plus a stainless steel crown. When a stainless steel crown is used instead of a band, the stainless steel crown must be separately identified.

Space maintainers are allowable for members up to age 20 only.

Prosthodontics (Fixed)

Topic #2903

An Overview

This information applies to BadgerCare Plus Standard Plan and Medicaid only.

Coverage of fixed prosthodontic services includes the following:

- Fixed partial denture pontics.
- Fixed partial denture retainers.
- Other fixed partial denture services.

The recementing of a fixed bridge, either of acid-etch retainer type or conventional crown/inlay/onlay retainers, is limited to permanent cementation.

PA (prior authorization) is required for fixed partial denture retainers, pontics, stress breakers and fixed partial denture repairs. Coverage is limited to members who cannot safely wear a removable partial denture due to a preexisting medical condition.

PA requests for fixed prosthetic services are only considered when the following criteria can be documented:

- The member cannot wear a removable partial or complete denture.
- The member has periodontally healthy teeth.

The following documentation must be submitted with a PA request for a fixed prosthodontic appliance:

- A minimum of periodontal charting and periapical radiographs of all abutment teeth.
- An explanation of unsuccessful wearing or attempt to wear a removable prosthetic appliance.
- Documentation that the member is physically, psychologically or otherwise indefinitely disabled or has a medical condition that imparts the treatment required (indicate in Element 4 of the Prior Authorization Dental Attachment 2).
- Periodontal case type (indiate in Element 12 of the Prior Authorization Dental Request form).

If necessary, diagnostic casts may be requested by BadgerCare Plus.

Topic #2904

Bridge Repair

Repairing a fixed bridge requires PA (prior authorization). The PA request for repair of a fixed prosthetic device is considered *only* when the following criteria can be documented:

- The fixed bridge is functional.
- The member has periodontally healthy teeth.

Prosthodontics (Removable)

Topic #2884

An Overview

This information applies to BadgerCare Plus Standard Plan and Medicaid only.

Coverage of removable prosthodontic services includes:

- Complete dentures.
- Partial dentures.
- Repairs to complete dentures.
- Repairs to partial dentures.
- Denture reline procedures.
- Maxillofacial prosthetics.

Wisconsin Medicaid reimburses dental providers for allowable removable prosthodontic services identified by BadgerCare Plus.

When submitting claims for partial and complete dentures, the following requirements must be met:

- Providers may use the date of final impressions as the DOS (date of service), but may not submit claims to BadgerCare Plus until the prosthesis is *inserted*.
- Members must be eligible on the date the final impressions are made in order for the denture service to be covered. If eligibility issues arise, providers will be asked to verify this date through treatment progress notes.

Topic #2888

Denture Repair Services

BadgerCare Plus requests that dentists use discretion with denture repairs. Old, worn dentures with severely worn teeth or fractures due to age should be replaced. A PA (prior authorization) request with appropriate documentation must be submitted for replacement dentures.

Providers are required to indicate an area of the oral cavity modifier (01, maxillary or 02, mandibular).

Wisconsin Medicaid reimburses a maximum amount per member, per denture, per six-month period for the repair of complete or partial dentures.

If laboratory costs exceed the maximum reimbursement allowed, dentists may submit a claim or adjustment request with laboratory bills.

Complete Denture Repairs

Complete denture repairs include the following:

- Repair of broken complete denture base.
- Replacement of missing or broken teeth.

Partial Denture Repairs

Repairs to partial dentures include the following:

- Repair of resin denture base.
- Repair of cast framework.
- Repair or replace a broken clasp.
- Replace broken teeth.
- Add tooth to existing partial denture.
- Add clasp to existing partial denture.
- Replace all teeth and acrylic on cast metal framework.

Noncovered Repairs

The following repairs are not covered by BadgerCare Plus:

- Extensive repairs of marginally functional dentures.
- Repairs to a denture when a new denture would be better for the health of the member.

Topic #2889

Edentulous Members

If a member has been edentulous for more than five years and has never worn a prosthesis, then no denture is ordinarily approved unless the dentist submits the following:

- A favorable prognosis.
- An analysis of the oral tissue status (e.g., muscle tone, ridge height, muscle attachments, etc.).
- Justification indicating why a member has been without a prosthesis.

If a member has not worn an existing prosthesis for three years, no new prosthesis will usually be authorized unless unusual mitigating circumstances and medical necessity are documented and verified by a physician.

When a member has a history of an inability to tolerate and wear a prosthetic appliance due to psychological or physiological reasons, then a new prosthesis will not be approved.

Topic #2890

Full Dentures with Few Remaining Teeth

Wisconsin Medicaid may reimburse for full dentures when a member has only one or two remaining teeth per arch if this treatment would maintain proper anchorage and if the denture could be converted to a full denture by a simple repair, in the event of tooth loss. The ForwardHealth dental consultant determines the appropriateness of this situation at the time prior authorization is requested.

Topic #2891

Healing Period After Tooth Extraction

BadgerCare Plus requires a minimum of six weeks healing period after the last tooth extraction occurs in the arch in question before a final impression is made.

A PA (prior authorization) request for dentures may be approved before teeth are removed. The six-week healing period must still take place. If the six-week waiting period does not take place, payment for dentures is denied or recouped.

Shorter Healing Period After Tooth Extraction

A shorter healing period after an extraction may be approved or no healing period may be required if the PA request demonstrates that such approval is appropriate due to medical necessity, an unusual medical condition, that only a few teeth are extracted, or that extracted teeth are in noncritical areas such as the opposing arch.

BadgerCare Plus may grant a shortened healing period or require no healing period in limited situations for members who are employed with job duties that require public contact. In this situation, a statement from the employer indicating the job duties that require public contact must be included in the PA request.

To have a shorter healing period, a provider must request the shorter period at the same time the PA request for dentures is made.

Immediate upper complete denture or upper complete denture with shorter healing period is authorized and billed using procedure code D5110. Immediate lower complete denture or lower complete denture with shorter healing period is authorized and billed using procedure code D5120.

Topic #2892

Life Expectancy of Prostheses

Generally, given reasonable care and maintenance, a prosthesis should last at least five years. Coverage of removable prosthodontic services is limited to one new full or partial denture per arch per five years unless unusual circumstances are documented with the PA (prior authorization) request. Providers and members should not expect to receive approval for a replacement prosthesis without adequate justification and documentation.

ForwardHealth assesses all cases that request early replacement of a prosthesis due to a member's poor adaptation to a new prosthesis, or poor quality workmanship by the provider.

Topic #2893

Lost, Stolen, or Severely Damaged Prostheses

Removable prosthodontic services are provided at considerable expense to BadgerCare Plus. BadgerCare Plus does not intend to repeatedly replace lost, severely damaged, or stolen prostheses. PA (prior authorization) requests for lost, severely damaged, or stolen prostheses are only approved when:

- The member has exercised reasonable care in maintaining the denture.
- The prosthesis was being used up to the time of loss or theft.
- The loss or theft is not a repeatedly occurring event.
- A reasonable explanation is given for the loss or theft of the prosthesis.
- A reasonable plan to prevent future loss is outlined by the member or the facility where the member lives.

In these situations, BadgerCare Plus will reimburse only for the first lost, damaged, or stolen prosthesis per arch. Subsequent lost, damaged, or stolen prostheses are payable by the member.

Prior Authorization Requirements

When submitting a PA request involving a lost, stolen, or severely damaged prosthesis, give special attention to the need for the prosthesis. The request must include a police report, accident report, fire report, or hospital, nursing home, or group home (community based residential facility) administrator statement or member statement on the loss. Such statements should include how, when, and where the prosthesis was lost or damaged, and what attempts were made to recover the loss and plans to prevent future loss.

Topic #3084

Obturator and Palatal Lift Prostheses

Obturator protheses definitive and palatal lift prostheses definitive do not require PA (prior authorization). These services may be provided once per six month period, and providers are required to retain documentation of medical necessity. Frequency limitations for these services may be exceeded in exceptional circumstances. Written justification must be included with a PA request.

Topic #2895

Partial Dentures

Wisconsin Medicaid reimburses for partial dentures *only* for members with good oral health and hygiene, good periodontal health (AAP (American Academy of Pediatrics) Type I or II), and a favorable prognosis where continuous deterioration of teeth and periodontal health is not expected.

A member qualifies for a partial denture if any of the following criteria are met:

- One or more anterior teeth are missing.
- The member has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
- The member has at least six missing teeth per arch, including third molars.
- A combination of one or more anterior teeth are missing, and the member has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
- The member requires replacement of anterior teeth for employment reasons.
- Medically necessary for nutritional reasons documented by a physician.
- Unusual clinical situations where a partial is determined to be necessary based on a comprehensive review of the dental and medical histories.

If placement of a partial denture in an arch provides at least two posterior teeth (posterior teeth are bicuspids and molars only) per quadrant in occlusion with the opposing quadrant, the opposing partial, if requested, may not be authorized unless the member also has an anterior tooth missing in that arch.

Topic #2896

Prior Authorization Requirements

PA (prior authorization) requests are required for the following:

- Complete dentures.
- Partial dentures.
- Replacement of all teeth and acrylic on cast metal frame work.

- Unspecified maxillofacial prosthesis.
- Frequency limitations for dentures, partials, and relines.

Complete and Partial Dentures

PA requests for a removable prosthesis should explain the individual needs of the member and include the following information:

- The age of existing prosthesis (if applicable).
- The date(s) of surgery, edentulation, or date the last tooth or teeth were extracted.
- The adaptability of the member. When appropriate, specifically document why a member is not wearing an existing prosthesis, and why a new prosthesis will eliminate the problem.
- The appropriateness of repairing or relining the existing prosthesis.
- Any misutilization practice of the member.
- Documented loss or damage of prosthesis requiring replacement, if applicable, and how future loss will be prevented.

Partial Dentures

Complete periodontal charting and X-rays sufficient to show entire arch in question; the BadgerCare Plus consultant may request additional information such as diagnostic casts on a case-by-case basis.

PA requests for partial dentures must include the following information:

- Periodontal status (AAP Type I-V).
- Verification that all abscessed or non-restorable teeth have been extracted or are scheduled to be extracted.
- Verification that all remaining teeth are decay-free or the member is scheduled for all restorative procedures.
- Success potential for proper completion and long-term maintenance of the partial denture.
- Verification that no tooth requires root canal therapy or that the member is responsible for any necessary root canals.

BadgerCare Plus may request additional documentation including a physician's statement to verify the following for complete or partial dentures:

- The medical necessity and appropriateness of the PA request.
- The prosthesis is necessary for proper nourishment and digestion.
- The member is physically and psychologically able to wear and maintain the prosthesis.
- The previous dentures have become unserviceable or lost.

Unspecified Maxillofacial Prostheses

Unspecified maxillofacial prostheses (D5999) require PA. PA requests for unspecified maxillofacial prostheses are approved based on medical necessity and appropriateness on a case-by-case basis. A laboratory bill and narrative must be included with the claim form.

Upgraded Partial Dentures

Wisconsin Medicaid reimburses dentists for providing upgraded partial dentures (D5213 and D5214), according to the following guidelines:

- PA is always required.
- Reimbursement is at the maximum fee for the "standard" resin-base partial denture (D5211 and D5212).
- Reimbursement must be accepted as payment in full.
- Each dental office that provides the service must have written criteria based on medical necessity to determine who receives the upgraded service.

- All criteria must be applied consistently to all BadgerCare Plus members.

No provider is obligated to provide upgraded partial dentures.

Topic #2897

Prostheses Care Instructions

As part of any removable prosthetic service, dentists are expected to instruct the member on the proper care of the prostheses. Six months of post-insertion follow-up care is included in the reimbursement for complete and partial dentures and relining complete and partial dentures.

Providers performing denture and partial denture adjustments after six months of post-insertion follow-up care may submit claims to ForwardHealth using procedure code D9110 for these services.

Topic #2898

Reline Services

Relining complete and partial upper and lower dentures is limited to once every three years, per arch, when an existing denture is loose or ill fitting or there is considerable amount of tissue shrinkage or weight loss. Six months of post-insertion follow-up care is included in reimbursement for complete and partial dentures and relining complete and partial dentures.

The frequency limitation for relines may be exceeded in exceptional circumstances. Written justification must be included with the PA (prior authorization) request.

Note: Chair-side reline services are **not** covered by BadgerCare Plus.

Topic #2899

Traumatic Loss of Teeth for Members Under Age 21

When a child experiences a traumatic loss of an anterior tooth or teeth (tooth numbers 6-11, 22-27), removable prostheses may be provided by backdating a PA request.

Restorative Services

Topic #2865

An Overview

Wisconsin Medicaid reimburses providers for restorative services (D2000-D2999). Restorations are expected to last for a reasonable time. Providers may exceed limitations *only* if a narrative on the submitted claim demonstrates the medical necessity for replacing a properly completed restoration.

Not all restorative services are covered under the Benchmark Plan; therefore, some information in this section may not apply to the Benchmark Plan.

BadgerCare Plus allowable dental restorative services include the following:

- Amalgam restorations.
- Resin-based composite restorations.
- Crowns — single restorations.
- Other restorative services.

ForwardHealth denies claims for replacement restorations performed in less than the allowable timeframe that fail to include a statement indicating why the restoration was replaced.

When performing restorative services, dental providers must follow the limitations and requirements identified by BadgerCare Plus for allowable restorative procedures, along with the following standards and guidelines:

- A restoration is considered a two or more surface restoration when two or more actual tooth surfaces are involved, whether they are connected or not.
- Any single or combination of restorations on one surface of a tooth is considered as one surface for reimbursement purposes.
- For claims submission purposes, count the total number of tooth surfaces restored and list the surface letters on the claim, even when unrelated surfaces are restored.

Services that are not reimbursable as separate procedures or billable to the member include the following:

- Services considered part of the restoration, including:
  - Base, copalite, or calcium hydroxide liners placed under a restoration.
  - The acid etching procedure for composite restorations or amalgam bonding.
- Local anesthesia, which is included in the restorative service fee.
- Sedative filling in conjunction with pulpotomy, endodontice therapy, or apexification.

Topic #2876

Crowns

BadgerCare Plus allowable crowns include anterior resin-based composite crowns, full-cast predominantly base metal crowns (upgraded crowns), prefabricated resin crowns, prefabricated stainless steel crowns with resin window, and prefabricated aesthetic coated stainless steel crowns. Dentists are not obligated to provide upgraded crowns.

For cases where Medicaid reimbursement for an upgraded crown (D2791) is less than the laboratory fee, providers may initiate reconsideration of an allowed claim by submitting an Adjustment/Reconsideration Request (F-13046 10/08)) along with a copy of the laboratory bill to receive additional reimbursement — up to the amount of the laboratory fee.

Topic #2875

Temporary Sedative Fillings

Temporary sedative fillings in conjunction with root canal procedures are reimbursed as part of the root canal procedure and are not separately reimbursable. They are not considered a small base before placement of a permanent restoration.

Topic #2877

Unspecified Restorative Procedures

Providers are required to include a periapical radiograph of the involved tooth or teeth with any PA (prior authorization) request for unspecified restorative procedures (D2999).

EHR Incentive Program

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EHR Incentive Program:Adopting, Implementing, or Upgrading Certified EHR Technology

Topic #12102

Adopting EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "adoption," Eligible Professionals and Eligible Hospitals must demonstrate acquisition, installation, or contractual proof of a future acquisition of certified EHR technology in the first payment year. All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospital for a period of six years. If selected for audit, the applicant must be able to supply one of the following items:

- Receipt(s) for certified EHR technology. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) for Health IT Certifed EHR Product List and reported through the application process.
- A contract for certified EHR technology. The products listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

Additional documentation may be considered but must, at a minimum, identify the certified EHR technology adopted and indicate the certified EHR technology acquired or purchased.

Topic #12103

Implementing EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "implementation," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting certified EHR technology and demonstrate actual implementation, installation, or utilization of certified EHR technology. Examples of how to demonstrate implementation of certified EHR technology includes completing a workflow analysis and redesign, training staff on the use of modules, and patient demographics and administrative data. All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospital for a period of six years. If selected for audit, the applicant must be able to supply at least one document from each of the following lists:

List One:

- Receipt(s) for certified EHR technology. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID that the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) Certified Health IT Product List and reported through the application process.
- A contract for certified EHR technology. The products listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

List Two:

- Maintenance agreement.
- Installation contract or receipts.
- System logs indentifying use of the certified technology and/or user license agreements.
- Evidence of cost, contract, or third party certification of certified EHR technology training.

Additional documentation may be considered but must, at a minimum, identify the certified EHR technology implemented and indicate the certified EHR technology acquired or purchased.

If attesting to "implementation," the Eligible Professional or Eligible Hospital will select from a list of implementation activities that are either "Planned" or "Completed." Some examples of these activities include workflow analysis, workflow redesigns, software installations, hardware installations, and peripheral installations.

Topic #12104

Upgrading EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "upgrade," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting and implementing and demonstrate expansion of the certified EHR technology's functionality such as the addition of an e-prescribing functionality or CPOE (Computerized Physician Order Entry). All information is subject to audit at any time and must be maintained by the Eligible Professional or Eligible Hospitals for a period of six years. If selected for audit, the applicant must be able to supply one of the following items:

- Receipt(s) for certified EHR technology. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) Certified Health IT Product List and reported through the application process.
- Executed contract for certified EHR technology. The products in listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

Additional documentation may be considered but must, at a minimum, identify the certified EHR technology upgraded and indicate the certified EHR technology acquired or purchased.

Topic #12497

Uploading Documentation for Adopting, Implementation, and Upgrading Certified EHR Technology

It is recommended, but not required, that Eligible Professionals and Hospitals provide documentation supporting adoption, implementation, or upgrading of certified EHR (Electronic Health Record) technology. If attesting to adoption, implementation or upgrade, the Eligible Professional or Hospital may upload supporting documentation at the conclusion of the Wisconsin Medicaid EHR Incentive Program application. Eligible Professionals and Hospitals may upload any relevant documentation to support their attestations related to adopting, implementing or upgrading. This may include PDF (Portable Document Format) files (of no more than 2MBs) of purchase orders, vendor contracts to install the certified EHR technology, any other receipts, and any other auditable documentation.

All Eligible Professionals and Hospitals are reminded that they should maintain supporting documentation for the Wisconsin Medicaid EHR Incentive Program application in their files for six years.

An Overview

Topic #12037

Overview of the EHR Incentive Program

The EHR (Electronic Health Record) Incentive Program was established under the American Recovery and Reinvestment Act of 2009, also known as the "Stimulus Bill," to encourage certain eligible health care professionals and hospitals to adopt and become meaningful users of certified EHR technology.

Under the federal law, Medicare and Medicaid have separate EHR incentive programs. Eligible Professionals may register to participate in either the Medicare or Medicaid EHR Incentive Programs, but not both. Eligible Professionals may change their EHR Incentive Program election once, switching between Medicare and Medicaid, but the change in election must occur on or before December 31, 2014. All Eligible Professionals must be Wisconsin Medicaid certified in order to participate in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals may participate in only one state's Medicaid EHR Incentive Program. Eligible Professionals should apply for EHR payments from the state with which they do most of their business.

Eligible Professionals must first register with the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals may then apply with the Wisconsin Medicaid EHR Incentive Program. All Wisconsin Medicaid EHR Incentive Program applications will be submitted through the secure Provider area of the ForwardHealth Portal.

Payments to Eligible Professionals will be made within 45 calendar days of the approval of a completed and submitted application. Eligible Professionals who meet all of the requirements may receive an incentive payment once per calendar year.

The Wisconsin Medicaid EHR Incentive Program will be available for Eligible Professionals from 2011 through 2021. The last date Eligible Professionals may register to begin receiving incentive payments for adopting, implementing, and upgrading EHR technology is December 31, 2016. Eligible Professionals may participate for a total of six years in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals are encouraged, but not required, to participate in all six allowed payment years.

The Wisconsin Medicaid EHR Incentive Program payment years are defined as calendar years and are composed in the following way:

- First payment year: Eligible Professionals are required to attest to adopting, implementing, or upgrading certified EHR technology.
- Second payment year: Eligible Professionals are required to demonstrate "meaningful use" of certified EHR technology during any 90-day, continuous period during the payment year.
- Third - sixth payment year: Eligible Professionals are required to demonstrate "meaningful use" of certified EHR technology for the entire payment year.

Eligible Professionals should note that they are not required to participate in consecutive years of the Wisconsin Medicaid EHR Incentive Program. For example, an Eligible Professional may register and complete all requirements for the first year in 2011 and receive a payment but then wait until 2013 to demonstrate "meaningful use" during a 90-day, continuous period for the second payment year.

All information submitted on the Wisconsin Medicaid EHR Incentive Program application is subject to audit at any time.

Appeals

Topic #12137

Appeals Process

To file an appeal, the Eligible Professional or Hospital should log into the secure ForwardHealth Portal and select the new quick link called the "Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program Appeal" on the secure Portal homepage.

Eligible Professionals and Hospitals (or an authorized preparer) filing a Wisconsin Medicaid EHR Incentive Program appeal should have the following information on hand when initiating an appeal:

- The NPI (National Provider Identifier) of the Eligible Hospital or Eligible Professional submitting the appeal.
- The payment year for which the appeal is being submitted.
- The name, telephone number, email address, and the preferred method of contact of the person submitting the appeal (i.e., the Eligible Hospital, Eligible Professional, or authorized preparer).

Once the Wisconsin Medicaid EHR Incentive Program has validated that the NPI matches a current application, the Eligible Professional or Hospital will then be able to select the reason to appeal from a drop-down list of reasons or will be able to provide a statement in a free-form comment box.

If the Wisconsin Medicaid EHR Incentive Program cannot match the NPI supplied with a current application, the Eligible Professional or Hospital will receive the following message: "A Wisconsin Medicaid EHR Incentive Program application that is denied or approved for payment is not found for the Eligible Hospital/Professional submitted. Please verify the information entered. If you believe this message was received in error, contact Provider Services." The Eligible Professional or Hospital should then contact Provider Services.

After selecting the reason for the appeal or providing a statement in the free-form comment box, the Eligible Professional or Hospital will then be able to upload any relevant supporting documentation in support of their appeal. This documentation may include any PDF (Portable Document Format) files up to 5 MBs each. Eligible Hospitals and Eligible Professionals should note that they must upload all relevant supporting documentation at the time of submission, as they will not be able to return to the appeal application to upload any documentation after submitting the appeal. Eligible Professionals and Eligible Hospitals will also have the option of creating a PDF of their appeal for their files.

After submission of the appeal, Eligible Professionals or Hospitals will receive a tracking number that is assigned to each appeal. Eligible Professionals and Hospitals should have this tracking number on hand to reference if they need to contact Provider Services regarding their appeal.

Once an appeal has been filed, the Eligible Professional or Hospital will receive an e-mail confirming the receipt of the appeal request and a second e-mail confirming that the appeal request has been adjudicated. The Wisconsin Medicaid EHR Incentive Program will communicate the appeal determination through a decision letter, sent to the address provided during Wisconsin Medicaid EHR Incentive Program application process, within 90 days of receipt of all information needed to make a determination. The decision letter will state whether the appeal has been denied or approved.

Topic #12477

Valid Reasons to Appeal

Eligible Professionals and Hospitals may only appeal to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive

Program for the following reasons:

- To dispute the payment amount.
- To appeal a denied Wisconsin Medicaid EHR Incentive Program application.

Appealing a Payment Amount

Eligible Professionals and Hospitals who wish to appeal a payment amount must do so within 45 calendar days of the RA (Remittance Advice) date of the Wisconsin Medicaid EHR Incentive Program payment.

Appealing a Denied Wisconsin Medicaid Electronic Health Record Incentive Program Application

Eligible Professionals and Hospitals who do not qualify for a Wisconsin Medicaid EHR Incentive Program payment will receive a denial letter in the mail, sent to the address provided during the Wisconsin Medicaid EHR Incentive Program application process. The letter will explain why their Wisconsin Medicaid EHR Incentive Program application was denied. Eligible Professionals and Hospitals who wish to appeal a denied Wisconsin Medicaid EHR Incentive Program application must do so within 45 calendar days from the date on the denial letter.

Eligible Professionals and Hospitals should refer to the tables below for the following information:

- A complete list of valid application denial appeal reasons.
- Additional supporting documentation that the Eligible Professional or Hospital may be required to upload based on the type of appeal, including instances when a statement is needed from the Eligible Professional or Hospital in the appeals application free-form comment box.
- Appealing the payment amount.

Denied Application Appeals	
Reason for Appeal	**Documentation Needed**
The patient volume required by the CMS (Centers for Medicare and Medicaid Services) have not been met, see federal rule 42 CFR 495.304.	• For Eligible Hospitals, provide the out-of-state patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application. • For Eligible Professionals, provide the patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application.
The Eligible Hospital has indicated it is not an acute care hospital with an average length of stay of 25 days or less or a children's hospital.	Acute care and children's hospitals are required to have an average length of stay for patients of 25 days or less to qualify for the Wisconsin Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement indicating the reason why the Eligible Hospital meets the requirements for the program.
The Eligible Hospital did not confirm to only participate in the Wisconsin Medicaid EHR Incentive Program.	Eligible Hospitals must agree to participate in only one state's Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Hospital confirms to only participate in the Wisconsin Medicaid EHR Incentive Program.
The Eligible Professional has indicated that	Upload documentation proving the Eligible Professional has been

they have current or pending sanctions with Medicare or Medicaid and therefore does not qualify for the Wisconsin Medicaid EHR Incentive Program.	reinstated by the Office of Inspector General. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional has no current or pending sanctions with Medicare or Medicaid.
The Eligible Professional has indicated that he or she is hospital based.	Eligible Professionals are not eligible for the Wisconsin Medicaid EHR Incentive Program if they provide 90 percent or more of their services to eligible members in an inpatient hospital or emergency department. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional is not hospital based.
The Eligible Professional has indicated they are not waiving their right to a Medicare EHR Incentive Program payment for this payment year. Eligible Professionals must select to register with either Medicare or Medicaid EHR Incentive Program, but not both.	Eligible Professionals may participate in either Medicare or Medicaid EHR Incentive Programs, but not both. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional is waiving their right to a Medicare EHR Incentive Program payment for this year.

Payment Amount Appeals	
Reason for Appeal	**Documentation Needed**
Eligible Professional payment amount (pediatrician only)	Provide the patient volume numbers for the reported 90-day period that should have been reported on the original Wisconsin Medicaid EHR Incentive Program application.
Eligible Hospital payment amount	Upload the Eligible Hospital's Medicare and Medicaid Cost Reports for the last four years.

Eligibility

Topic #12038

Eligible Professionals for EHR Incentive Program

To be eligible to participate in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program, an Eligible Professional must be certified with Wisconsin Medicaid as one of the following:

- Advanced practice nurse prescriber with psychiatric specialty.
- Dentist.
- Nurse midwife.
- Nurse practitioner.
- Physician.
- PAs (physician assistants). Only PAs practicing in an FQHC (Federally Qualified Health Center) or RHC (Rural Health Clinic) are considered Eligible Professionals.

Note: Under the federal law, only PAs practicing in an FQHC or RHC that is so led by a PA are considered Eligible Professionals. "So led" is defined in the federal regulation as one of the following:

- When a PA is the primary provider in a clinic.
- When a PA is a clinical or medical director at a clinical site of practice.
- When a PA is an owner of an RHC.

Eligible Professionals will not be eligible for the Wisconsin Medicaid EHR Incentive Program if they provide 90 percent or more of their services rendered to eligible members in an inpatient hospital or emergency department. Less than 90 percent of all services rendered to eligible members must take place outside place of service code "21" (Inpatient Hospital) and "23" (Emergency Room - Hospital).

Financial Information

Topic #12120

835 Health Care Claim Payment/Advice Transaction

To assist trading partners in identifying Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments received for an Eligible Professional or organizations on the 835 (835 Health Care Claim Payment/Advice) transaction, the NPI (National Provider Identifier) of the Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment will appear in segment PLB01 of the 2110 Loop. The PLB03-1 segment identifies the adjustment reason code. A code of LS will represent a positive incentive payment while a code of WO will represent a recovery of a previously paid incentive payment. The PLB04 segment will represent the monetary amount that is either paid or recouped based on the Adjustment Reason Code displayed in PLB03-1.

Topic #12118

Electronic Funds Transfer

Eligible Professionals who assign payments to themselves as individuals may elect to receive paper checks but are encouraged to set up an EFT (electronic funds transfer). EFTs allow ForwardHealth to directly deposit payments into the group's or Eligible Professional's designated bank account for a more efficient delivery of payments. An EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Eligible Professionals that assign payments to an organization or clinic must supply the organization's EFT number. Organizations receiving payment from an Eligible Professional may only receive incentive payments through their existing EFT account.

Refer to the Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal for information on EFT enrollment.

Topic #12117

Example of a Six-Year Payment Schedule for an Eligible Professional

Eligible Professionals who complete all the requirements for each applicable payment year will receive incentive payments in lump sums, as listed in the following table. Eligible Professionals may begin registering for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program beginning in 2011 and up until 2016.

Calendar Year	**Wisconsin Medicaid Eligible Professionals***					
	2011	2012	2013	2014	2015	2016
2011	$21,250	—	—	—	—	—
2012	$8,500	$21,250	—	—	—	—
2013	$8,500	$8,500	$21,250	—	—	—
2014	$8,500	$8,500	$8,500	$21,250	—	—
2015	$8,500	$8,500	$8,500	$8,500	$21,250	—

2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	—	$8,500	$8,500	$8,500	$8,500	$8,500
2018	—	—	$8,500	$8,500	$8,500	$8,500
2019	—	—	—	$8,500	$8,500	$8,500
2020	—	—	—	—	$8,500	$8,500
2021	—	—	—	—	—	$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

*Pediatricians with a minimum of 20 percent eligible member patient volume, but less than 30 percent eligible member patient volume will receive two-thirds of the incentive payment amounts. Eligible pediatricians will receive $14,167 in their first payment year, $5,667 in their second payment year, and $42,500 in their third through sixth payment years.

Topic #12105

Incentive Payment Information

Eligible Professionals who meet all of the requirements will receive an incentive payment once per calendar year. Eligible Professionals must assign payment to either themselves or their organization's federal TIN (tax identification number).

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments for Eligible Professionals may only be assigned to either the Eligible Professional themselves or the group practice assigned for the pay-to address on the Wisconsin Medicaid provider file. Eligible Professionals should ensure that the most current group practice is assigned for the pay-to address. Eligible Professionals can check this information via their ForwardHealth Portal Account in the "Demographic" section.

Topic #12119

Remittance Advice

Financial Transactions Section

Eligible Professionals and Eligible Hospitals will see the following information under the "Non-Claim Specific Payouts to Payee" section within the financial transactions page of the TXT (text) version of the RA (Remittance Advice) as well as within Section 130 of the CSV (comma-separated value) downloadable file:

- All Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments will appear under the "Non-Claim Specific Payouts to Payee" section of the RA.
- Amounts identified with the Reason Code 0247 will designate the amount as a Wisconsin Medicaid EHR Incentive Program payment.
- Amounts identified with the Reason Code 0248 will designate the amount as a Wisconsin Medicaid EHR Incentive Program positive adjustment.
- Payments reported in this section are processed and mean the same as any other ForwardHealth payment identified within this section.
- A new field has been added, called "Related Provider ID," to identify the NPI (National Provider Identifier) of the individual Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment.

Eligible Professionals and Eligible Hospitals will see the following information on the "Accounts Receivable" section within the Financial Transactions page of the TXT version of the RA as well as within Section 150 of the CSV downloadable file:

- If a negative adjusting entry is required to adjust the original Wisconsin Medicaid EHR Incentive Program incentive payment issued, an Accounts Receivable transaction will be generated to initiate the adjusting entry. All Wisconsin Medicaid EHR Incentive Program payment adjustments will be identified with the Reason Code 0265 (EHR Payment Adjustment). The Wisconsin Medicaid EHR Incentive Program payments are subject to recoupment as a result of any monies owed to ForwardHealth.
- The Wisconsin Medicaid EHR Incentive Program payment adjustments are processed and report on the RA as they do today under the Accounts Receivable section.

Summary Section

The Earnings Data section on the Summary section of the TXT version of the RA and the Sections 160 (Summary Net Payments) and Section 180 (Summary Net Earnings) of the CSV downloadable file will include the Wisconsin Medicaid EHR Incentive Program payments and adjustments reported on the Financial Transactions section. The process for calculating and reporting the net payments and earnings for the Summary section has not changed.

Patient Volume

Topic #12098

Eligible Member Patient Volume

The federal law 42 CFR s. 495.306(c)(1) stipulates that only certain services rendered to certain members that are reimbursed with Medicaid (Title XIX) funds may be counted towards eligible member patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines eligible members as those members enrolled in the programs listed here.

Eligible Professionals using the eligible member patient volume method must meet a minimum patient encounter volume threshold of one of the following:

- At least 30 percent of their patient volume attributed to eligible members over a continuous 90-day period in the calendar year preceding the payment year.
- Pediatricians will be considered eligible if 20 percent of their patient encounter volume is attributable to eligible members but will receive two-thirds of the incentive amounts. If a pediatrician's patient encounter volume is 30 percent or higher, the incentive payments are the same as any other Eligible Professional.

Note: Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

An eligible member patient encounter is defined as services rendered on any one day to an eligible member where Medicaid or BadgerCare Plus paid all or part of the service including copayments or any other cost-sharing. Eligible Professionals must have submitted a claim to ForwardHealth or a state-contracted managed care organization and received reimbursement of at least $0.01 to be counted as a patient encounter for an eligible member.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR Incentive Program only considers services provided to members that are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for 2011 is 8.08 percent.

To figure out the eligible member patient encounters, the Eligible Professional must multiply the total eligible member encounter patient volume by a factor of (1-.0808) or .9192 and then divide that number by the total eligible member patient encounter volume. The final number should be rounded to the nearest whole number (i.e., .01 through .49 should be rounded down and .50 through .99 should be rounded up to the nearest number.)

Eligible Professionals using the eligible member patient volume method may elect to calculate patient volume at the individual or group practice level. If an Eligible Professional calculates their patient encounter volume based on a group practice level, the entire group practice's patient encounter volume must be included. This includes the services rendered by all providers within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifier). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following

conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the group practice is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their eligible member patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate their eligible member patient volume at an individual level and assign payment to their group practice. Conversely, an Eligible Professional may calculate their eligible member patient volume at a group practice level and assign payment to themselves.

Eligible Professionals calculating group practice patient volume under the eligible member patient volume must meet a minimum of at least 30 percent of their patient volume attributed to eligible members. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the group and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12101

Example of Calculating Group Practice Patient Volume

Eligible Professionals must have at least 30 percent of their patient volume encounters attributed to eligible members. When electing to use group practice patient volume, the entire practice's patient volume must be included. This includes the services rendered by all Eligible Professionals within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Groups are defined by how their businesses are enumerated under their NPI (National Provider Identifier).

The following is an example of calculating group practice volume for the purpose of establishing eligibility for the Wisconsin Medicaid EHR Incentive Program.

Eligible Provider	Provider Type	Total Encounters (Eligible Members/Total)	Percentage of Eligible Member Encounters
Yes	Physician	80/200	40 percent
Yes	Nurse Practitioner	50/200	50 percent
Yes	Physician	0/100	0 percent
No	Registered Nurse	150/200	75 percent
No	Pharmacist	80/100	80 percent
Yes	Physician	30/300	10 percent
Yes	Dentist	5/100	5 percent
Yes	Dentist	60/200	30 percent

In this scenario, there are 1300 encounters in the selected 90-day period. Of the 1300 encounters, 455 are attributable to eligible members, or 35 percent. The next step is to apply the standard deduction (1-.0808=0.9192) to the number of eligible members.

455 * 0.9192 = 418.236

That number is divided by the total number of encounters in the selected 90-day period, or 1300.

418.236 / 1300 = 32.172

Therefore, the group practice patient volume is 32.172 percent, which is rounded to the nearest whole number of 32 percent, and is eligible for the Wisconsin Medicaid EHR Incentive Program.

Eligible Professionals should note that even though one dentist's eligible member encounter percentage was only 5 percent and one physician's eligible member encounter percentage was 10 percent, when included in the group practice patient volume, both are eligible for the program when registering with the group practice patient volume. The physician whose eligible member encounter percentage is zero is not eligible for the program because he or she did not render services to at least one eligible member.

Topic #12100

Example of Calculating Individual Patient Volume

Eligible Professionals must have at least 30 percent (except pediatricians, who must have at least 20 percent) of their patient volume attributed to eligible members. For example, if an Eligible Professional calculates his or her total eligible member patient encounter volume of 35 out of a total patient encounter volume of 75, the eligible member patient volume is 46.66 percent, rounded to 47 percent.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program only considers services provided to members who are reimbursed with funding directly from Medicaid (Title XIX) as a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for 2011 is 8.08 percent.

To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter patient volume by a factor of (1-.0808) or .9192 and then divide that number by their total eligible member patient encounter volume.

Standard Deduction Calculation

Total eligible member patient encounters during any 90-day continuous period * .9192

---------- * 100

Total patient encounters, regardless of payer over that same 90-day continuous period

-Or-

35 * .9192

---------- * 100 = 42.896 percent

75

So the final eligible member patient encounter volume is 32.17 encounters out of 75 total, or 42.896 percent, rounded to the nearest whole number, 43 percent.

Therefore, 43 percent of the Eligible Professional's patient volume is eligible members and the Eligible Professional fulfills the patient volume requirement for the Wisconsin Medicaid EHR Incentive Program.

Topic #12097

Members Who May Be Counted When Determining Patient Volume

Most members enrolled in the programs listed below are considered eligible members and may be counted when determining patient encounters and patient volume:

- Wisconsin Medicaid.
- BadgerCare Plus Standard Plan.
- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Express Enrollment for Pregnant Women.
- Alien Emergency Service Only.
- TB-Only (Tuberculosis-Related Service Only) Benefit.
- Family Planning Only Services.

Note: There are certain members enrolled in these programs or certain services provided to eligible members that may be included in the patient volume, which is the reason for the standard deduction.

Topic #12099

Needy Individual Patient Volume

The federal law stipulates that only certain services rendered to certain individuals may be counted towards the needy individual patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines needy individuals as those listed here as well as those who are provided uncompensated care by the provider, or individuals provided services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Only Eligible Professionals, including pediatricians, practicing in an FQHC (Federally Qualified Health Center) or RHC (Rural Health Clinic) may use the needy individual patient volume method. In order to meet the definition of practicing predominantly in an FQHC or RHC, the clinical location for more than 50 percent of all services must be in an FQHC or RHC for at least a six-month period of the previous calendar year.

Eligible Professionals using the Needy Individual Patient Volume method must meet a minimum of 30 percent needy individual patient volume threshold. Needy Individual Patient Volume encounters consist of the following:

- Services rendered on any one day to an individual where Medicaid or BadgerCare Plus paid all or part of the service including copayments or any other cost-sharing.
- Services rendered on any one day to an individual where Children's Health Insurance Program under Title XXI paid for part or all of the service.
- Services rendered on any one day to an individual furnished by the provider as uncompensated care.
- Services rendered on any one day to an individual furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Eligible Professionals using the Needy Individual Patient Volume method may elect to calculate patient volume at an individual or a group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice, the entire

group practice's patient volume must be included. This includes the services rendered by all providers within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the organization is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire group practice's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their needy individual patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate his or her needy individual patient volume at an individual level and assign payment to the group practice. Conversely, an Eligible Professional may calculate his or her needy individual patient volume at a group practice level and assign payment to him- or herself.

Eligible Professionals calculating group patient volume under the needy individual patient volume must meet a minimum of at least 30 percent of their patient volume attributed to needy individuals. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the organization and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12078

Patient Volume Requirements and Calculations

In addition to other EHR (Electronic Health Record) Incentive Program requirements, Eligible Professionals must meet patient volume thresholds over the course of a 90-day period for each Eligible Professional in the preceding calendar year, chosen by the applicant at the time of application. Eligible Professionals may enter any 90-day period that starts and ends in the previous calendar year.

When reporting patient volume, Eligible Professionals will designate which practice locations are using certified EHR technology and enter the relevant patient encounter data needed to determine eligibility. Patient encounter data will be entered in three parts for each practice location:

- The total (in-state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total (regardless of state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total patient encounter volume (regardless of state or payer) over the previously determined continuous 90-day reporting period.

When attesting to Wisconsin Medicaid EHR Incentive Program patient volume requirements, there are two methods by which an Eligible Professional may calculate patient volume.

- Eligible member patient volume.

- Needy individual patient volume.

Each patient volume method contains its own unique requirements; however, only Eligible Professionals practicing in an FQHC (Federally Qualified Health Center) or RHC (Rural Health Clinic) may use the needy individual patient volume method.

Registration and Applying

Topic #12057

Individuals Applying for the EHR Incentive Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider Portal account.

An Eligible Professional applying as an individual needs to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The Eligible Professional needs to first log in to the Portal. If the Eligible Professional does not have a Portal account, he or she needs to obtain one. The Eligible Professional should refer to the Account User Guide on the Portal User Guides page of the Provider area of the Portal for more information on obtaining a Portal account.
- The Eligible Professional needs to click on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The Eligible Professional will have to designate payment to either him- or herself or to the organization.

Topic #12040

Organizations Applying for the EHR Incentive Program on Behalf of Eligible Professionals

A secure Provider Portal account is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider ForwardHealth Portal account.

Organizations applying on behalf of Eligible Professionals need to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The organization needs to first log in to the Portal. The organization only needs one Portal account to apply for all Eligible Professionals assigning payment to their organization and associated with the organization's federal TIN (tax identification number). If the organization does not have a Portal account, it needs to obtain one. Refer to the Account User Guide on the Portal User Guides page of the Provider area of the Portal for more information on obtaining a Portal account.
- Portal Administrators will automatically have access to the Wisconsin Medicaid EHR Incentive Program application. Organizations may assign the new "EHR Incentive" role to a clerk to conduct all Wisconsin Medicaid EHR Incentive Program business.
- The organization may access the EHR Incentive Program application by clicking on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The organization will see a list of all Eligible Professionals that are associated with the organization's TIN. The organization will have to submit a separate application for each Eligible Professional associated with their TIN. Organizations should note that once an application has begun for an Eligible Professional, only the Portal account used to begin the application can access that Eligible Professional's application.

Topic #12039

Registration for the EHR Incentive Program with CMS

All Eligible Professionals are required to first register at the R&A (Medicare and Medicaid Electonic Health Record Incentive Program Registration and Attestation System)Web site. A step-by-step walkthrough of the R&A registration process for Eligible Professionals is also available online.

After an Eligible Professional successfully registers on the R&A, CMS (Centers for Medicare and Medicaid Services) will process the registration and send the file to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. After receipt of the file, the Wisconsin Medicaid EHR Incentive Program will enter all relevant information into the ForwardHealth system. Eligible Professionals must wait two full business days before beginning the application for the Wisconsin Medicaid EHR Incentive Program to allow for this process.

Topic #12058

Required Information When Starting the EHR Incentive Program Application

Eligible Professionals will be required to supply specific information when completing the EHR (Electronic Health Record) Incentive Program application. Eligible Professionals do not have to complete the entire application in one session. The application will allow users to save the information entered and return later to complete the application.

Eligible Professionals should have the following information available when beginning the application:

- Information submitted to the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals will need to confirm all of this information during the initial application phases.
- Contact name, telephone number, and e-mail address of the authorized preparer of the Eligible Professional's application, if not the Eligible Professional.
- Information regarding whether or not the Eligible Professional applying to the Wisconsin Medicaid EHR Incentive Program has any sanctions or pending sanctions with the Medicare or Medicaid programs and is licensed to practice in all states in which services are rendered.
- The CMS (Centers for Medicare and Medicaid Services) EHR certification ID for the certified EHR technology the Eligible Professional already has or is contractually obligated to acquire. For more information on approved EHR technology, Eligible Professionals should refer to the ONC (Office of the National Coordinator for Health Information Technology)-certified EHR product list.
- Required Patient Volume Data:
  - The total in-state eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
  - The total eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
  - The total patient encounter volume over the previously determined continuous 90-day reporting period.

Topic #12077

Reviewing, Confirming, and Submitting the EHR Incentive Program Application

After completing attestations for the EHR (Electronic Health Record) Incentive Program, the Eligible Professional will be asked to review all answers provided. An error-checking function will identify any errors found in the application.

Final submission will require an electronic signature by providing the preparer or the Eligible Professional's initials, the Eligible Professional's NPI (National Provider Identifier) and the Eligible Professional's personal TIN (tax identification number). If completed through the use of an authorized preparer, that preparer will also need to include his or her name and relationship to the

Eligible Professional and then electronically sign the application before submission. Once the Wisconsin Medicaid EHR Incentive Program application has been completed and submitted, an e-mail notification will be sent to confirm the application's submission. After an application is successfully submitted and approved, Eligible Professionals can expect payments within 45 days.

Resources for EHR Incentive Program

Topic #12138

Provider Services

Eligible Professionals and Eligible Hospitals should call Provider Services at (800) 947-9627 with all questions regarding the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program.

Topic #12139

User Guide

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program User Guides for Eligible Professionals and Eligible Hospitals are available on the Portal User Guides page of the Provider area of the ForwardHealth Portal.

Topic #12140

Web Sites

The following Web sites provide additional information regarding the EHR (Electronic Health Record) Incentive Program.

Available Resources	Web Sites
Wisconsin Medicaid EHR Incentive Program Web Site	www.dhs.wisconsin.gov/ehrincentive/
CMS (Centers for Medicare and Medicaid Services) EHR Incentive Program	https://www.cms.gov/EHRIncentivePrograms/
Wisconsin Health Information Technology Extension Center Web Site	www.whitec.org/

Managed Care

6

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Managed Care:Claims

Topic #385

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 (health maintenance organization) or SSI (Supplemental Security Income) 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 (Managed Care Program Provider Appeal, F-12022 (03/09)) 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.

Topic #384

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #386

Claims Submission

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) 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.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Element 18 of the paper 1500 Health Insurance Claim Form.
- 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

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #389

Provider Appeals

When a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 HMO 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

Topic #390

Covered Services

HMOs

HMOs (health maintenance organizations) are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI (Supplemental Security Income) HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental.
- Chiropractic.

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

The following are not covered by BadgerCare Plus HMOs (health maintenance organizations) or Medicaid SSI (Supplemental Security Income) HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS (Community Recovery Services).
- CSP (Community Support Program) benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC (child care coordination) services.
- Pharmacy services and diabetic supplies.
- PNCC (prenatal care coordination) services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related administration codes.
- SBS (school-based services).
- Targeted case management services.
- NEMT (non-emergency medical transportation) services for most Wisconsin Medicaid and BadgerCare Plus members. Wisconsin Medicaid and BadgerCare Plus members who are enrolled in an HMO in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine counties receive NEMT services from their respective HMOs.
- DOT (directly observed therapy) and monitoring for TB-only (Tuberculosis-Only Related Services).

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan are eligible for enrollment in a BadgerCare Plus HMO (health maintenance organization).

An individual who receives the TB-Only (Tuberculosis-Related Services-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 (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI (Supplemental Security Income) 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 (managed care organization).

Topic #394

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs (health maintenance organizations) 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 (Supplemental Security Income) HMO's enrollment process and provide contact 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.

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits.
- Telephone and face-to-face support.
- Assistance with enrollment, disenrollment, and exemption procedures.

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO (health maintenance organization) 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 (Supplemental Security Income) HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.
- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

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

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO (health maintenance organization) is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO (health maintenance organization) program, the Medicaid SSI (Supplemental Security Income) 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.

Topic #402

Managed Care Contracts

The contract between the DHS (Department of Health Services) and the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #404

SSI HMO Program

Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) 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 (prior authorization) 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.

Topic #403

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 (Program of All-Inclusive Care for the Elderly), 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

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) HMOs may develop PA (prior authorization) guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Provider Information

Topic #406

Copayments

Providers cannot charge Medicaid SSI (Supplemental Security Income) HMO (health maintenance organization) 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.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 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.

Topic #408

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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 (Department of Health Services) and the HMO or SSI HMO.
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider.
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services).

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) HMOs may cover

medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) 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.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO 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:01/03/2012

Member Information:Birth to 3 Program

Topic #792

Administration and Regulations

In Wisconsin, Birth to 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 DHS (Department of Health Services) monitors, provides technical assistance, and offers other services to county Birth to 3 agencies.

The enabling federal legislation for the Birth to 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 Birth to 3 agency for more information.

Topic #790

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for Birth to 3 services if the child meets one of the following criteria:

- The child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The child 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.
- The child has atypical development affecting his or her overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

BadgerCare Plus provides Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus members.

Topic #791

Individualized Family Service Plan

A Birth to 3 member receives an IFSP (Individualized Family Service Plan) developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, services appropriate to meet the needs of the child and family, and the natural environment settings where services will be provided. All Birth to 3 services must be identified in the child's IFSP.

Topic #788

Requirements for Providers

Title 34 CFR Part 303 for Birth to 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 Birth to 3 services. These children must be referred to the appropriate county Birth to 3 program within *two working days* of identification. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. 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 Birth to 3 program for evaluation. (Providers are encouraged to explain the need for the Birth to 3 referral to the child's parents or guardians.)
- Cooperate and participate with Birth to 3 service coordination as indicated in the child's IFSP (Individualized Family Services Plan). Birth to 3 services must be provided by providers who are employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services.
- Deliver Birth to 3 services in the child's natural environment, unless otherwise specified in the IFSP. The child's natural environment includes the child's home and other community settings where children without disabilities participate. (Hospitals contracting with a county to provide therapy services in the child's natural environment must receive separate certification as a therapy group to be reimbursed for these therapy services.)
- Assist parents or guardians of children receiving Birth to 3 services to maximize their child's development and participate fully in implementation of their child's IFSP. For example, an occupational therapist is required to work closely with the child's parents and caretakers to show them how to perform daily tasks in ways that maximize the child's potential for development.

Topic #789

Services

The Birth to 3 Program covers the following types of services when they are included in the child's IFSP (Individualized Family Services Plan):

- Evaluation and assessment.
- Special instruction.
- OT (occupational therapy).
- PT (physical therapy).
- SLP (speech and language pathology).
- Audiology.
- Psychology.
- Social work.
- Assistive technology.
- Transportation.
- Service coordination.
- Certain medical services for diagnosis and evaluation purposes.
- Certain health services to enable the child to benefit from early intervention services.
- Family training, counseling, and home visits.

Enrollment Categories

Topic #785

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 (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #9297

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 (health maintenance organizations).

As of March 19, 2011, new enrollment into the Basic Plan ended. The Basic Plan will continue for members already enrolled in the Basic Plan.

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 BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD (institution for mental disease).
- 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 (Wisconsin Chronic Disease Program), 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 (Health Insurance Risk-Sharing Plan) 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.

Alternatives to the BadgerCare Plus Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1: Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and $150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below $33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than $10,000 would pay $89 per month for a $2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool will offer the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.
Enrollment is expected to begin in July 2010, for coverage beginning August 1, 2010.

If you enroll in BadgerCare Plus Basic or HIRSP now, you will not be eligible for the Federal Pool. You should determine which program best serves your needs. For more information about HIRSP or the Federal Pool and your insurance options, please contact HIRSP Customer Service at 1.800.828.4777 or visit *www.hirsp.org*

Topic #5557

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) 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 Family Planning Only Services or those benefits provided to individuals who qualify for the TB-Only (Tuberculosis-Related Services Only) Benefit.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL (federal poverty level).
- 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

Individuals who wish to enroll may apply for the Core Plan using the ACCESS tool online or via the ESC (Enrollment Services Center). 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 (Department of Justice) and the Department of HHS (Health and Human Services') OIG (Office of the Inspector General).

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 (Institution for Mental Disease).
- 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 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 (Department of Health Services) 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 (Wisconsin Chronic Disease Program), 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 (Health Insurance Risk Sharing Plan) 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.

Topic #225

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 are enrolled in BadgerCare Plus HMOs (health maintenance organizations). In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Topic #6917

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 (Federal Poverty Level). 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 (over-the-counter) 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.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits 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.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive-related services to low-income individuals who are at least 15 years of age who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age. Members receiving Family Planning Only Services must be receiving routine contraceptive-related services.

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under the Wisconsin Medicaid and BadgerCare Plus family planning benefit (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during contraceptive-related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive-related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive-related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other service options and provide referrals for care not covered by Family Planning Only Services.

Temporary Enrollment for Family Planning Only Services

Members whose providers are submitting an initial Family Planning Only Services application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE (temporary enrollment) for Family Planning Only Services for up to two months. Services covered under the TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

To determine enrollment for Family Planning Only Services, providers should use the income limit for 300 percent of the FPL (Federal Poverty Level).

TE for Family Planning Only Services providers may issue white paper TE for Family Planning Only Services 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.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid managed care programs.
- SeniorCare.
- WCDP (Wisconsin Chronic Disease Program).
- WIR (Wisconsin Immunization Registry).
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP (Wisconsin Well Woman Program).

ForwardHealth interChange is supported by the state's fiscal agent, HP (Hewlett-Packard).

Topic #229

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Expansion for Certain Pregnant Women.
- EE (Express Enrollment) for Children.
- EE for Pregnant Women.
- Family Planning Only Services, including TE (Temporary Enrollment) for Family Planning Only Services.
- QDWI (Qualified Disabled Working Individuals).
- QI-1 (Qualifying Individuals 1).
- QMB Only (Qualified Medicare Beneficiary Only).
- SLMB (Specified Low-Income Medicare Beneficiary).
- TB-Only (Tuberculosis-Related Services-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, Family Planning Only Services, 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 Family Planning Only Services and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS (Wisconsin's Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

Topic #228

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in 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 (Supplemental Security Income).
- WWWP (Wisconsin Well Woman Program).

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA (Social Security Administration) offices.

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs (managed care organizations).

Topic #10217

Members Enrolled in the Wisconsin Well Woman

Program and the BadgerCare Plus Basic Plan

Women may be enrolled in the WWWP (Wisconsin Well Woman Program) and the BadgerCare Plus 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 (Wisconsin Well Woman Medicaid) 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.

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their local county or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiaries).

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They receive payment of the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 1) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their 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 (Federal Poverty Level).
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Topic #262

Tuberculosis-Related Services-Only Benefit

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

Topic #240

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer.
- Cervical cancer.
- Precancerous conditions of the cervix.

Services provided to women who are enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

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 are eligible to be enrolled in WWWMA. 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.

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. 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.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the ForwardHealth Enrollment and Benefits (P-00079 (10/11)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will *not* reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #2564

Orthodontic and Prosthodontic Services Exceptions

Exceptions to the loss of eligibility in mid-treatment include dental prosthodontic services and orthodontic treatment. BadgerCare Plus makes exceptions due to the complexity, cost, and long-term nature of these services. Providers are reminded that Wisconsin Medicaid reimburses providers for services that have been prior authorized in situations where a member moves into an eligibility category where dental services are not ordinarily covered.

Orthodontic Treatment

The date of band placement for orthodontic treatment is the determination date for reimbursement. If a member becomes ineligible while receiving orthodontic treatment, Wisconsin Medicaid will continue to reimburse the dentist for completion of orthodontic services when bands are placed during the member's period of eligibility. If the member was eligible on the date the bands were placed, Wisconsin Medicaid will reimburse dentists *only for those services for which PA (prior authorization) was granted*.

Prosthodontic Services

The date of the final impression for prosthodontic services is the determination date for reimbursement. If a member becomes ineligible while receiving fixed or removable prosthodontic treatment, Wisconsin Medicaid will continue to reimburse the dentist for completion of prosthodontic services when final impressions were taken during the member's period of eligibility. If the member was eligible on the date the final impression was made, Wisconsin Medicaid will reimburse dentists *only for those services for which PA was granted*.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS (date of service) that services are provided. Pursuant to 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 (durable medical equipment) suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets his or her ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state.
- A change in income.
- A change in family size, including pregnancy.
- A change in other health insurance coverage.
- Employment status.
- A change in assets for members who are over 65 years of age, blind, or disabled.

Enrollment Rights

Topic #246

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 (Division of Hearings and Appeals).

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 (DHA-28 (08/09)) 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.

Topic #247

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted MCO (managed care organization) or assigned to the Pharmacy Services Lock-In Program.

Topic #248

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Topic #250

Notification of Discontinued Benefits

When the DHS (Department of Health Services) intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, 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.

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Identification Cards

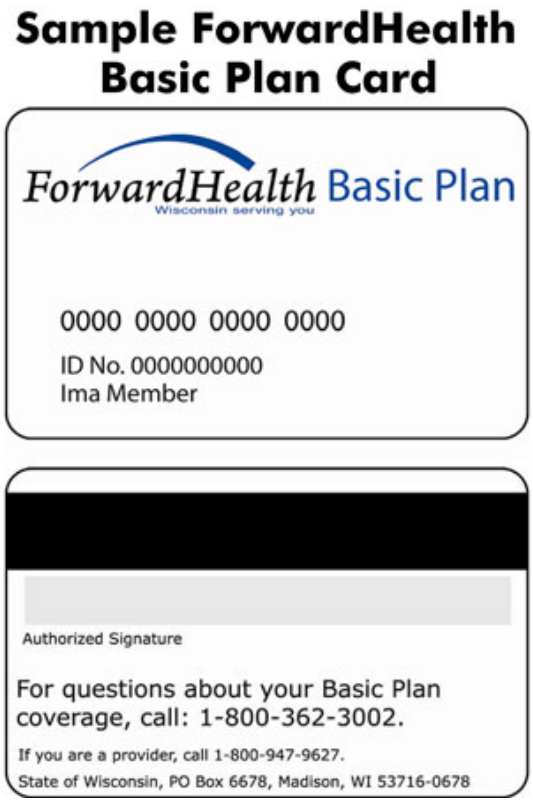
Topic #9357

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 (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 with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.



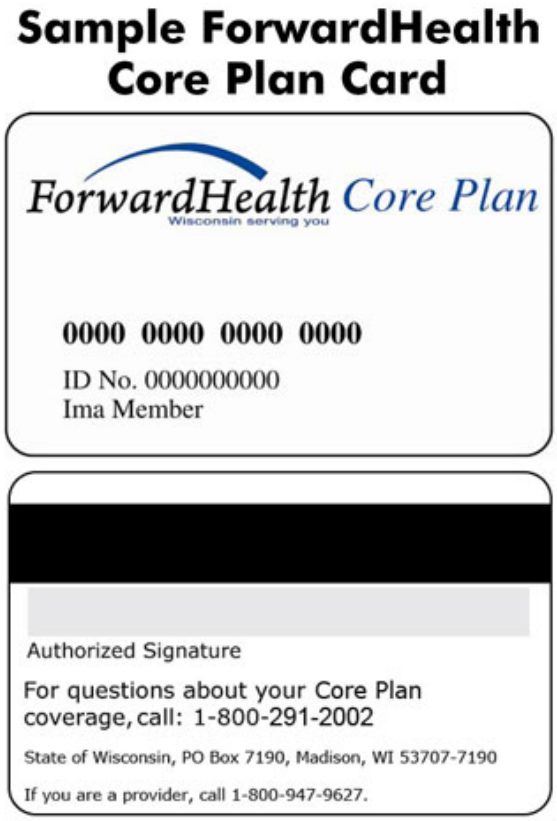
Topic #6977

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 Member Services with questions about enrollment criteria, HMO (health maintenance organization) enrollment, and covered services.

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.



Topic #266

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

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 (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, 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 (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Topic #268

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE (Temporary Enrollment) for Family Planning Only Services identification cards for members to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application (F-10119).

The TE for Family Planning Only Services identification cards have the following message printed on them: "Temporary Identification Card for Temporary Enrollment for Family Planning Only Services." Providers should accept the white TE for Family Planning Only Services identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Topic #267

Temporary Express Enrollment Cards

There are two types of temporary EE (Express Enrollment) 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 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. A beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process.

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 (Enrollment Verification System) to verify enrollment for DOS (dates of service) after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Sample Express Enrollment Cards

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for pregnant women	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. You are temporarily enrolled in BadgerCare Plus for outpatient pregnancy-related services. Your enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. To get regular BadgerCare Plus or Wisconsin Medicaid, you must apply online, by mail or in person: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400

To learn more, see your Rights and Responsibilities.

To the Provider

The individual listed has been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive pregnancy related outpatient care including pharmacy services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

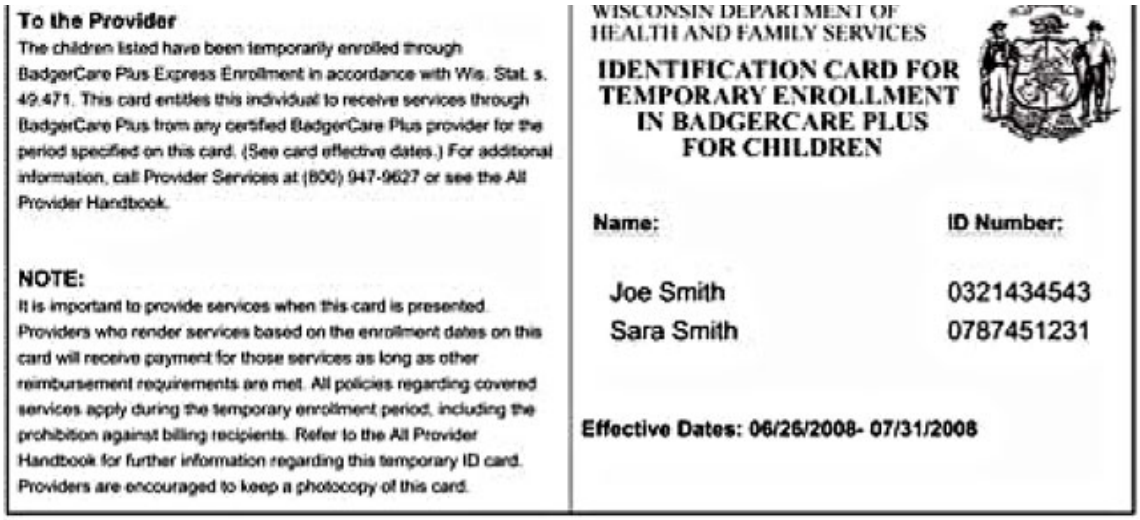
IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR PREGNANT WOMEN

Name:	ID Number:
Jane Smith	0454782131

Effective Dates: 06/26/2008- 07/31/2008

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for children	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. The following individual(s) is/are temporarily enrolled in BadgerCare Plus: • **Joe Smith** • **Sara Smith** This temporary enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. In order to continue receiving BadgerCare Plus you must apply through one of the following methods: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400

To learn more, see your Rights and Responsibilities.



To the Provider

The children listed have been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services as long as other reimbursement requirements are met. All policies regarding covered services apply during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR CHILDREN

Name:	ID Number:
Joe Smith	0321434543
Sara Smith	0787451231

Effective Dates: 06/26/2008- 07/31/2008

Topic #270

Temporary ForwardHealth Identification Cards

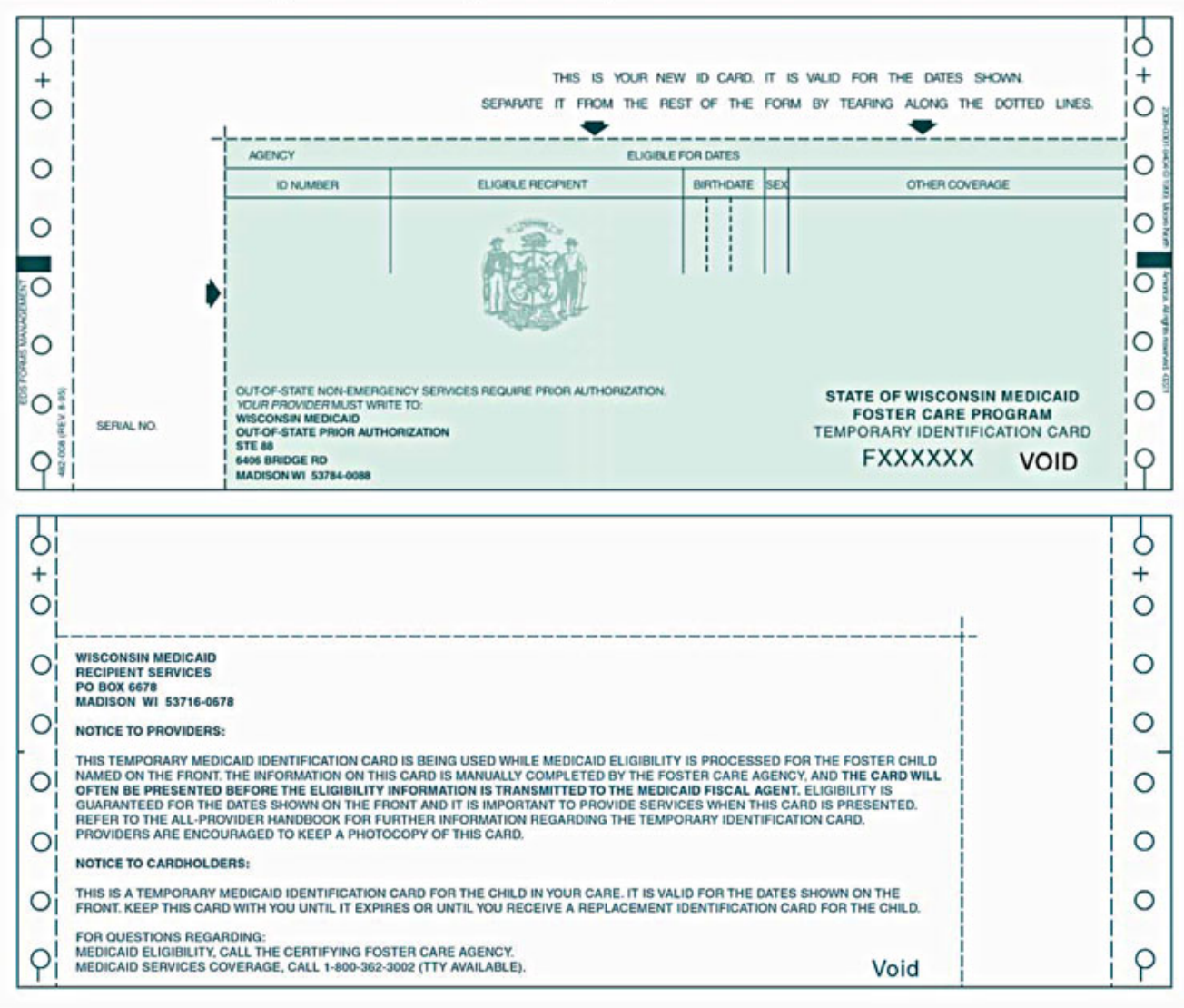
All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should 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 (date of service) 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.

Sample Temporary Medicaid Card



Topic #1435

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.
- White plastic SeniorCare cards.
- Green paper temporary cards.
- Paper printout temporary card for EE (Express Enrollment) for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE (Temporary Enrollment) for Family Planning Only Services cards.

Member Enrollment

Topic #2828

Eligibility Requirements

Limited Benefit Categories

Some members do not have dental coverage or have very limited dental coverage because they are Medicaid eligible only for a limited-benefit category. Providers are reminded that Wisconsin Medicaid reimburses providers for services that have been prior authorized in situations where a member moves into an eligibility category where dental services are not ordinarily covered.

Members Enrolled in Managed Care Organizations

Some members enrolled in Medicaid HMOs and SSI HMOs have dental coverage through their HMO. If a dentist without HMO affiliation provides *non-emergency* dental care to a Medicaid member with HMO dental coverage, neither the HMO nor Medicaid will reimburse the dentist for those services. Neither can the dentist hold the member liable.

Therefore, *before* providing any non-emergency dental services, a dentist should always check whether a Medicaid member is enrolled in a Medicaid or SSI HMO and whether the HMO provides dental coverage. Eligibility information, including HMO dental coverage, is available through the AVR (Automated Voice Response) system.

If a non-network dentist provides *emergency* dental care to a member with HMO dental coverage, the HMO will reimburse the dentist according to conditions of payment established in the HMO's contract with Wisconsin Medicaid.

Dental providers are paid on a fee-for-service basis for services provided to a managed care program enrollee if the managed care program does not offer dental services, or if the enrollee received prosthodontia (fixed), prosthodontia (removable), or orthodontia treatment before the member was enrolled in a Medicaid-contracted managed care program.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Topic #272

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.

Topic #274

Pharmacy Services Lock-In Program

Information is available for DOS (dates of service) before April 1, 2011.

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions.
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service.
- Not seeking duplicate care from more than one provider for the same or similar condition.
- Not seeking medical care that is excessive or not medically necessary.

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI (Supplemental Security Income) HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR, physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (i.e., due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (e.g., home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids.
- Barbiturates used for seizure control.
- Lyrica®.
- Provigil® and Nuvigil®.
- Weight loss drugs.

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by HID (Health Information Designs, Inc.). HID may be contacted by telephone at (800) 225-6998, extension 3045, by fax at (800) 881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Health Information Designs
391 Industry Dr
Auburn AL 36832

Pharmacy Services Lock-In Prescribers Are Required to Be Certified by Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be certified by Wisconsin Medicaid. Certification for the Pharmacy Services Lock-In Program is not separate from certification by Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The Lock-In prescriber determines what restricted medications are medically necessary for the member, prescribes those medications using his or her professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (12/10)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the Lock-In prescriber may also contact the Lock-In pharmacy to give the pharmacist (s) guidelines as to which medications should be filled for the member and from whom. The primary Lock-In prescriber should also coordinate the provision of medications with any other prescribers he or she has designated for the member.

The Lock-In pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Designated Lock-In Pharmacies

Information is available for DOS (dates of service) before April 1, 2011.

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their Lock-In prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically

designated to do so by the primary Lock-In prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless he or she has been designated by the Lock-In prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than his or her Lock-In prescriber or Lock-In pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary Lock-In prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be certified by Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-Lock-In prescriber to the designated Lock-In pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated Lock-In prescriber, alternate prescriber, Lock-In pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the prescription is not from a designated Lock-In prescriber, the Lock-In pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the Lock-In pharmacy provider may contact the Lock-In prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the Lock-In pharmacy provider may do one of the following:

- Speak to the member.
- Call HID.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated Lock-In prescriber, alternate Lock-In prescriber, Lock-In pharmacy, or alternate Lock-In pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

Exceptions

Certain exceptions will be made regarding Pharmacy Services Lock-In Program requirements. The following are exempt from Pharmacy Services Lock-In Program requirements:

- Out-of-state providers who are not certified by Wisconsin Medicaid.
- Administration of drugs during an emergency room visit.

If a member enrolled in the Pharmacy Services Lock-In Program presents a prescription for a restricted medication from an emergency room visit or an out-of-state provider, the pharmacist at the Lock-In pharmacy must attempt to contact the Lock-In prescriber to verify the appropriateness of filling the prescription. If the pharmacy provider is unable to contact the Lock-In prescriber, the pharmacist should use his or her professional judgment to determine whether or not the prescription should be filled. If the prescription is filled, the claim must be submitted on paper using the Pharmacy Special Handling Request (F-13074 (04/11)) form.

The ForwardHealth emergency medication dispensing policy does not apply to the Pharmacy Services Lock-In Program. Drugs dispensed in an emergency to Pharmacy Services Lock-In Program members are nonreimbursable services except as noted above. Providers cannot collect payment from Pharmacy Services Lock-In Program members for nonreimburseable services.

For More Information

Providers may call HID with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members.
- A member's enrollment in the Pharmacy Services Lock-In program.
- A member's designated Lock-In prescriber or Lock-In pharmacy.

Topic #273

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Topic #276

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus and Wisconsin Medicaid cover medical services in any of the following circumstances:

- An emergency illness or accident.
- When the member's health would be endangered if treatment were postponed.
- When the member's health would be endangered if travel to Wisconsin were undertaken.
- When PA (prior authorization) has been granted to the 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.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (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 (continuously eligible

newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within 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 (F-1162 (02/09)) 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.

Topic #724

Out-of-State Youth Program

The OSY (Out-of-State Youth) 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

Topic #278

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.

Topic #280

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-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 (prior authorization) was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from 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 (date of service) due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #281

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.
- The provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update (F-10109 (07/08)) 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

8

Archive Date:01/03/2012

Prior Authorization:Decisions

Topic #424

Approved Requests

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

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

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

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

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as 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.

Topic #5038

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, 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 (prior authorization) request or amendment request via the Portal to ForwardHealth for processing.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) decision notices and provider review letters via the secure area of the ForwardHealth Portal. 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.

Topic #425

Denied Requests

When a PA (prior authorization) request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about 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 (Prior Authorization Request Form, F-11018 (10/08)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (10/08)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (10/08)).
- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a noncovered service.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #4737

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA (prior authorization) request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Topic #427

Returned Requests

A PA (prior authorization) request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the PA is finalized.

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

Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) requirement may be waived for services that normally require PA. Emergency services are defined in 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.

Topic #430

Urgent Services

Telephone consultations with DHCAA (Division of Health Care Access and Accountability) staff regarding a prospective PA (prior authorization) request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the member or unnecessary costs for Medicaid as determined by the DHCAA. All telephone consultations for urgent services should be directed to the Quality Assurance and Appropriateness Review Section 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.

Follow-Up to Decisions

Topic #4738

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the 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 (prior authorization) 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.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (10/08)) to amend an approved or modified PA (prior authorization) request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. 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.

Topic #432

Appeals

If a PA (prior authorization) request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA (Division of Hearings and Appeals). Decisions that may be appealed include the following:

- Denial or modification of a PA request.
- Denial of a retroactive authorization for a service.

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (10/08)) to enddate most PA (prior authorization) requests. ForwardHealth does not accept requests to enddate a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be enddated by using STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to enddate a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be enddated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Topic #4739

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA (prior authorization) appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. 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 and dental models will be returned once the amendment request is finalized.

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

Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) requests, regardless of how the PA was initially submitted. If the provider knows the PA number, 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

Topic #2834

An Overview

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

- The PA/DRF (Prior Authorization Dental Request Form, F-11035 (10/08)).
- A PA/DA1 (Prior Authorization/Dental Attachment 1, F-11010 (10/08)) or a PA/DA2 (Prior Authorization/Dental Attachment 2, F-11014 (10/08)).
- Additional supporting clinical documentation.

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (10/08)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (10/08)), or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (10/08)), a service-specific PA (prior authorization) attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

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

Topic #2833

Prior Authorization/Dental Attachment 1

The PA/DA1 (Prior Authorization/Dental Attachment 1, F-11010 (10/08)) allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service(s). Dental providers should use the PA/DA1 for certain services within the following categories:

- Anesthesia/professional visits.
- Endodontic services.
- Periodontic services.
- Prosthodontic services.

Prior Authorization/Dental Attachment 2

The purpose of the PA/DA2 (Prior Authorization/Dental Attachment 2, F-11014 (10/08)) is to document the medical necessity of certain services within the following categories.

- Fixed prosthetic services.
- Oral surgery services.
- Orthodontic services.

Topic #447

Obtaining Forms and Attachments

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

Paper Forms

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

ForwardHealth
Form Reorder
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 (Portable Document Format) and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (10/08)) and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Topic #2831

The PA/DRF (Prior Authorization Dental Request Form, F-11035 (10/08)) may be downloaded and printed in its original format from this Web site. Providers may order paper copies of the PA/DRF from Form Reorder at the previously listed address.

Topic #2830

Prior Authorization Dental Request Form

The PA/DRF (Prior Authorization Dental Request Form, F-11035 (10/08)) is used by ForwardHealth and is mandatory for dental providers when requesting PA (prior authorization). The PA/DRF serves as the cover page of a PA request.

A sample PA/DRF is available.

Providers are required to complete the basic provider, member, and service information on the PA/DRF. 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.

Multiple-Page Requests

ForwardHealth accepts PA requests with a maximum of 26 details per PA request. The ForwardHealth PA/RF (Prior Authorization Request Form, F-11018 (10/08)) has space for 10 items. If a provider's PA request requires more than 12 items to be listed, the provider may continue the PA request on a second and third PA/RF. When submitting a PA request with multiple pages, indicate the page number and total number of pages for the PA/RF in the upper right hand corner (e.g., "page 1 of 2" and "page 2 of 2").

In addition, the total charges should be indicated in Element 24 of the last page of the PA/DRF. On the preceding pages, Element 24 should refer to the last page (for example, "see page 2").

PA Numbers

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). The PA number will no longer be pre-printed on the PA/DRF.

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11035 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization Dental Request Form (PA/DRF) Completion Instructions, F-11035A.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable
- ☐ HealthCheck "Other Services"
- ☐ Wisconsin Chronic Disease Program

2. Process Type (Check one)
- ☒ 124 (Dental)
- ☐ 125 (Ortho)

3. Telephone Number — Billing Provider
(XXX) XXX-XXXX

4. Name and Address — Billing Provider (Street, City, State, ZIP Code + 4)
I.M. Provider
1 W. Williams St.
Anytown, WI 55555-1234

5a. Billing Provider Number
0111111110

5b. Billing Provider Taxonomy
123456789X

6a. Rendering Provider Number
0222222220

6b. Rendering Provider Taxonomy
123456789X

SECTION II — MEMBER INFORMATION

7. Member Identification Number
1234567890

8. Date of Birth — Member
MM/DD/CCYY

9. Address — Member (Street, City, State, ZIP Code)
609 Willow St.
Anytown, WI 55555

10. Name — Member (Last, First, Middle Initial)
Member, Im A.

11. Gender — Member
☐ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

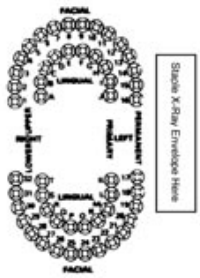
12. Place of Service
☒ Dental Office (POS "11") ☐ Outpatient Hospital (POS "22") ☐ Ambulatory Surgical Center (POS "24")
☐ Skilled Nursing Facility (POS "31") ☐ Other (specify): _____

14. Area of Oral Cavity	15. Tooth	16. Procedure Code	17. Modifier	18. Description of Service	19. Quantity Requested	20. Charge
		D5110		**Complete denture - maxillary**	**1**	**XXX.XX**

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

21. Total Charges **XXX.XX**

13. Dental Diagram
- Check periodontal case type if applicable.
  - ☐ I
  - ☒ II
  - ☐ III
  - ☐ IV
  - ☐ V
- Cross out missing teeth.
- Circle teeth to be extracted.



Number of X-rays **4**
Type of X-rays **2 BW, 2 PA**

22. **SIGNATURE** — Rendering Provider
I.M. Provider

23. Date Signed
MM/DD/CCYY

24. **SIGNATURE** — Member / Guardian (if applicable)

25. Date Signed

Topic #7797

Prior Authorization Request Form Completion Instructions for Prescribers for Drugs

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 (prior authorization) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/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 all applicable service-specific attachments on the ForwardHealth Portal, 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)
Leave the box next to HealthCheck "Other Services" blank. Enter an "X" in the box next to WCDP (Wisconsin Chronic Disease Program) if the services requested on the PA/RF (Prior Authorization Request Form, F-11018 (10/08)) are for a WCDP member.

Element 2 — Process Type
Enter process type 131 — Drugs. The process type is a three-digit code used to identify a category of service requested. PA requests will be returned without adjudication if no process type is indicated.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their telephone number as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the telephone number of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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.

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their name and address as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the name and address of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their provider number as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the provider number of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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

Note: Prescribers who are certified by Wisconsin Medicaid should indicate their taxonomy code as the billing provider on PA requests. Prescribers who are not certified by Wisconsin Medicaid should indicate the taxonomy code of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated on PA requests.

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 (Enrollment Verification System) 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 (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

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.

Element 15 — Requested PA Start Date
Enter the requested start DOS (date of service) in MM/DD/CCYY format.

Element 16 — Rendering Provider Number
Enter the prescriber's NPI, only if the NPI is different from the NPI of the billing provider listed in Element 5a.

Element 17 — Rendering Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the prescriber only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 18 — Procedure Code (not required)

Element 19 — Modifiers (not required)

Element 20 — POS
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 21 — Description of Service
Enter the drug name and dose for each item requested (e.g., drug name, milligrams, capsules).

Element 22 — QR
Enter the appropriate quantity (e.g., days' supply) requested for each item requested.

Element 23 — Charge (not required)

Element 24 — Total Charges (not required)

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting this 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).

Topic #449

Supporting Clinical Documentation

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

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

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

Topic #2912

Dental services providers should refer to the appropriate PA attachment to determine what supporting clinical documentation is required to be submitted with each PA request.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Topic #434

Communication with Members

ForwardHealth recommends that providers inform members that PA (prior authorization) is required for certain specified services *before* delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the *entire* PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Topic #435

Definition

PA (prior authorization) is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA *before* providing services that require PA. When granted, a PA

request is approved for a specific period of time and specifies the type and quantity of service allowed.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and dental models.

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

Providers 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 (F-1181 (10/08)) form.

Topic #436

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA (prior authorization). 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 (Department of Health Services).

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to 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.

Topic #438

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA (prior authorization) request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is certified by Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101 through DHS 109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43 through 49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Grant and Expiration Dates

Topic #439

Backdating

Backdating an initial PA (prior authorization) request or SOI (spell of illness) 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.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Topic #442

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA (prior authorization) 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

Topic #443

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and enddates, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Topic #4919

Loss of Enrollment During Treatments

Exceptions to the loss-of-enrollment-midway-through-treatment rule are if a member becomes ineligible while receiving dental prosthodontia treatments or orthodontic treatment.

Members are not financially responsible for dental prosthodontia and orthodontic treatment received after their enrollment has ended.

Topic #444

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS (date of service). The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.
- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (10/08)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (10/08)), and PA/DRF (Prior Authorization/Dental Request Form, F-11035 (10/08)) 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.

Topic #451

Clinical Review

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

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to 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. DHS 107 that meets certain criteria.

Determination of Medical Necessity

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

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

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

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

Services Requiring Prior Authorization

Topic #2734

Services Requiring Prior Authorization

Dental Services

The following dental services require PA (prior authorization):

- Intraoral radiograph (D0210) and panoramic film (D0330), if frequency limitations are exceeded.
- Molar root canal therapy (D3330) for members ages 21 and over.
- Periodontal scaling, root planing, and periodontal maintenance (D4341, D4342, D4910).
- Full-mouth debridement (D4355) for members ages 12 and under.
- Full and partial dentures (D5110, D5120, D5211-D5226).
- Repairs to partial dentures including replacement of all teeth and acrylic on cast metal framework (maxillary and mandibular) (D5670-D5671).
- Fixed prosthodontics (D6211-D6971, D6940-D6980).
- Orthodontic services (D8010-D8692, excluding D8660).

Oral Surgery Services

PA is required for members 21 years of age and older in a nonemergency situation. PA is never required when an emergency is indicated on the claim form.

Services That Do Not Require Prior Authorization

ForwrdHealth does not require PA for the following services when they are provided by a pediatric dentist (D9241 and D9248) or an oral surgeon (D9220, D9241, and D9248) for a member less than 21 years of age on the DOS (date of service):

- D9220 (deep sedation/general anesthesia — first 30 minutes).
- D9241 (intravenous conscious sedation/analgesia — first 30 minutes).
- D9248 (non-intravenous conscious sedation).

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

- A copy of the existing PA request, if possible.
- A new PA request, including the required attachments and supporting documentation indicating the new billing provider's name and address and billing provider number.
- A letter requesting the 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.

Topic #5197

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA (prior authorization) 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.

Topic #453

Examples

Examples of when a new PA (prior authorization) request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (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.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

On and after January 1, 2012, providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction on January 1, 2012.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should follow the PA fax procedures.
- Providers should *not* fax the same PA request more than once.
- Providers should *not* fax *and* mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a

confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet (F-1176 (01/10)) 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) 224-6124.

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 (Prior Authorization Request Form, F-11018 (10/08)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (10/08)) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at (608) 224-6124, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1:00 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 by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.

- Change the status of a PA request from Suspended to Pending.
- Submit additional supporting documentation for a PA request that is in Suspended or Pending Status.
- Search and view previously submitted PA requests.
- 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 (National Provider Identifier) 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 (Prior Authorization/"J" Code Attachment, F-11034 (10/08)), and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet (F-11159 (10/08)) 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 (Prior Authorization Request Form, F-11018 (10/08)) that was completed on the Portal.

Note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA 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 Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA forms and is pertinent for processing the PA request or PA amendment request. Providers have the following options for submitting additional supporting clinical information for PA requests or PA amendment requests.

- Upload electronically.

- Mail.
- Fax.

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).
- OrthoCAD™ (.3dm) (for dental providers).

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with a ".rtf" extension; and PDF files must be stored with a ".pdf" extension. Dental OrthoCAD™ files are stored with a ".3dm" extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA or PA amendment that is in a Returned — Provider Review status.
- Submitting a PA amendment.

If submitting supporting clinical information via mail or fax, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or the pertinent information is difficult to find.

Suspended Prior Authorization Requests

For PA requests in a suspended status, the provider has the option to:

- Change a PA request status from Suspended to Pending.
- Submit additional documentation for a PA request that is in Suspended or Pending status.

Changing a Prior Authorization Request from Suspended to Pending

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determined that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA, checking the box indicating that the PA is ready for processing without additional documentation, and clicking the Submit button to allow the PA to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA can be processed.

Submitting Additional Supporting Clinical Documentation for a Prior Authorization Request in Suspended or Pending Status

There is a "Upload Documents for a PA" link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. Prior

authorization requests in a "Pending" status are processed regardless.

Note: When the PA request is in a pending status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
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.

Topic #457

STAT-PA

Providers can submit STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) 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 (prior authorization) requests.

NPI (National Provider Identifier) 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

9

Archive Date:01/03/2012

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (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 or Medicaid) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus or Medicaid.

Topic #4380

Benchmark Plan Reimbursement Amount

Maximum allowable fees for the BadgerCare Plus Benchmark Plan are set at 101 percent of the 50th percentile of the *American Dental Association 2005 Survey of Dental Fees — East North Central Region.*

Topic #694

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.

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.

- Out-of-state providers.
- Out-of-country providers.
- SMV (specialized medical vehicle) providers during their provisional 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 "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 Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (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 Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT (text) 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.

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #2885

Maximum Daily Reimbursement for Dentists

Wisconsin Medicaid has a maximum payment for the following services provided to a single member on a single day:

- All radiographs.
- Selected oral surgery emergency services.
- All dental services.

Topic #4385

Pharmacy Services and Some Drug-Related Supplies

Pharmacy services and some drug-related supplies for managed care members are reimbursed by fee-for-service.

The following provider-administered drugs and related administration codes are reimbursed by fee-for-service, not a member's MCO (managed care organization), for members enrolled in BadgerCare Plus HMOs, Medicaid SSI (Supplemental Security Income) HMOs, and most special managed care programs if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related administration codes.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

MCOs are responsible for reimbursing providers for all other provider-administered drugs, such as drug claims submitted with a CPT (Current Procedural Terminology) code, such as CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each).

Prescription drugs and related services and provider-administered drugs for members enrolled in the PACE (Program of All-Inclusive Care for the Elderly) and the Family Care Partnership are provided and reimbursed by the special managed care program.

Claims

Claims for drug-related supplies should be submitted with the appropriate HCPCS (Healthcare Common Procedure Coding System) procedure code indicated.

Collecting Payment From Members

Topic #4381

Benchmark Plan Cost Sharing

Requirements

Benchmark Plan members who are children under 19 years of age are responsible for payments for the following:

- A deductible of the first $200.00 for covered services per enrollment year, based on the Benchmark Plan maximum allowable fee schedule.
- Fifty percent of the maximum allowable fee for each service once the $200.00 deductible is met.

Preventive and diagnostic services are exempt from the $200.00 deductible but are subject to the 50 percent cost-sharing requirement.

All pregnant women are exempt from cost-sharing, including the deductible and the 50 percent cost-sharing requirement.

Providers are not required to accept members in the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to pay any required cost sharing.

Billing Benchmark Plan Members for Services

Benchmark Plan members are responsible only up to the Benchmark Plan maximum allowable fee for dental services once a provider collects the $200.00 deductible or the remaining 50 percent of the maximum allowable fee if the deductible has already been met. Services received in an enrollment year that exceed the $750.00 limit per enrollment year are considered noncovered services. Noncovered services can be billed directly to the member at the provider's usual and customary charge. Dental service providers are strongly urged to obtain from the member a written and signed waiver of liability for noncovered services.

Examples of Cost Sharing Under the Benchmark Plan

In the first example, a child enrolled in the Benchmark Plan sees a dentist for a limited exam (D0140), a panoramic X-ray (D0330), a periapical X-ray (D0220), and a subsequent extraction (D7140). The maximum allowable fees for these services are as follows:

- Limited exam, $47.00.
- Panoramic X-ray, $82.00.
- Periapical X-ray, $19.00.
- Extraction, $100.00.

The total for these services is $248.00.

Because the exam and X-rays are considered preventive and diagnostic, they are exempt from the $200.00 annual deductible but not from the $750.00 annual limit. These services are reimbursed by BadgerCare Plus to the provider at 50 percent of the maximum allowable fee with the member responsible for the balance. The provider would receive $23.50 from BadgerCare Plus for the limited exam, $41.00 for the panoramic X-ray, and $9.50 for the periapical X-ray for a total of $74.00, which is applied to the member's $750.00 annual limit. The member is responsible for the remaining $74.00 for these services.

The extraction is subject to the $200.00 annual deductible, so the member is responsible for the full $100.00. This amount is not applied to the member's $750.00 annual limit.

In the second example, a dental provider sees a child enrolled in the Benchmark Plan as a new patient. This member receives a new patient exam (D0150), a full mouth X-ray (D0210), an adult prophylaxis (D1110), and restoration (D2140, D2150, D2160).

The maximum allowable fees for these services are as follows:

- New patient exam, $50.00.
- Full mouth X-ray, $90.00.
- Adult Prophylaxis, $60.00.
- Restorations, $313.00.

The total for these services is $513.00.

Because the exam, X-ray, and prophylaxis are considered preventive and diagnostic, they are exempt from the $200.00 annual deductible but not from the $750.00 annual limit. These services are reimbursed by BadgerCare Plus to the provider at 50 percent of the maximum allowable fee with the Benchmark Plan member responsible for the balance. The provider would receive $25.00 from BadgerCare Plus for the new patient exam, $45.00 for the full mouth X-ray, and $30.00 for the adult prophylaxis. The member is responsible for the remaining $100.00 for these services.

The restorations are subject to the $200.00 annual deductible, so the member is responsible for the first $200.00 and then 50 percent of the $113.00 balance for a total of $256.50 ($200.00 deductible plus 50 percent, or $56.50, of the remainder). BadgerCare Plus would reimburse the remaining $56.50.

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met *prior* to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Topic #538

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, 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 from the member *only* the Medicaid or BadgerCare Plus copayment amount indicated on the member's remittance information.

Topic #224

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, *except* for the following:

- Required member copayments for certain services.
- Commercial insurance payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid certification.

Copayment

Topic #2827

Amounts

Standard Plan and Medicaid

Copayment amounts for dental services 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

The copayment for most CPT (Current Procedural Terminology) oral surgery services is $3.00.

Benchmark Plan

Benchmark Plan members do not have copayments for dental services.

Core Plan

Dental services under the BadgerCare Plus Core Plan for Childless Adults do not have copayments.

Basic Plan

Dental services under the Basic Plan have a $10 copayment per visit.

Topic #231

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:

- Children in a mandatory coverage category. In Wisconsin, this includes:
  - Children in foster care, regardless of age.
  - Children in subsidized adoption, regardless of age.
  - Children in the Katie Beckett program, regardless of age.

    - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
    - Children ages 1 through 5 with income up to 185 percent FPL.
    - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally-ill individuals receiving hospice care.
- Nursing home residents.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP (Community Support Program) services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN (private duty nursing) and PDN services for ventilator-dependent members.
- SBS (school-based services).
- 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:

- Children in a mandatory coverage category. In Wisconsin, this includes:
    - Children in foster care, regardless of age.
    - Children in subsidized adoption, regardless of age.
    - Children in the Katie Beckett program, regardless of age.
    - Children under age one with income up to 150 percent of the FPL (Federal Poverty Level).
    - Children ages 1 through 5 with income up to 185 percent FPL.
    - Children ages 6 through 18 years of age with incomes at or below 100 percent of the FPL.
- Children who are American Indian or Alaska Natives who are enrolled in the state's CHIP (Child Health Insurance Program).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally-ill individuals receiving hospice care.
- Nursing home residents.

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 WWWMA (Wisconsin Well Woman Medicaid) from the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for any Medicaid covered service.

Topic #233

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 (health maintenance organization).
- 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.

Topic #237

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.

Topic #239

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

Topic #242

Instances When Medicaid Is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are *not* the payer of last resort for members who receive coverage from certain governmental programs, such as:

- Birth to 3.
- Crime Victim Compensation Fund.
- GA (General Assistance).
- HCBS (Home and Community-Based Services) waiver programs.
- IDEA (Individuals with Disabilities Education Act).
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP (Wisconsin Chronic Disease Program).
    - Adult Cystic Fibrosis.
    - Chronic Renal Disease.
    - Hemophilia Home Care.

Providers should ask members if they have coverage from these other governmental programs.

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

Topic #251

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans.
- Commercial managed care plans.
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration).
- Other governmental benefits.

Topic #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus 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 (managed care organization).

Topic #255

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Topic #2826

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.

Noncovered Services for Dentists and Physicians

Under DHS 107.07(4), Wis. Admin. Code, unless the service is part of a dental assessment and evaluation for a member under 21 years of age or is found necessary as a result of such an assessment and evaluation, the following dental services are not covered under BadgerCare Plus whether or not the service is performed by a dentist; physician; or a person under the supervision of a dentist or physician:

1. General services for purely aesthetic or cosmetic purposes.
2. General services performed by means of a telephone call between a provider and a member, including those in which the provider provides advice or instructions to or on behalf of the recipient, or between dentists, physicians, or a dentist and physician on behalf of the recipient.
3. Equivalent services or separate components of a service performed on the same day.
4. Tests and laboratory examinations, other than for diagnostic casts when required by the department.
5. Oral hygiene instruction or training in preventive dental care as a separate procedure, including tooth brushing technique, flossing or use of special oral hygiene aids, tobacco cessation counseling, or nutritional counseling.
6. The following restorative services:
    1. Labial veneer.
    2. Temporary crowns.
    3. Cement bases as a separate item.
    4. Endodontic filling materials that are not approved for use by the American Dental Association.
7. Pulp cappings.
8. The following removable prosthodontic services:
    1. Overlay dentures.
    2. Overlay partial dentures.
    3. Duplicate dentures and adjustments.
9. The following implant services:
    1. Tooth implants.
    2. Transplantations.
    3. Surgical repositioning except reimplantation under sub. (3).
    4. Transseptal fiberotomies.
10. Orthodontic services, except as specified under sub. (2) (a) 5.
11. The following adjunctive general services:
    1. Professional consultation.
    2. Non-surgical treatment of temporomandibular joint disorder.
    3. Behavior management.
    4. Athletic mouthguards.
    5. Local anesthesia as a separate procedure.
    6. Occlusal guard, analysis and adjustment.
    7. Non-covered services that are listed in s. DHS 107.03.
12. Professional visits, other than for the oral evaluation of a nursing home resident, or hospital calls as noted in sub. (1) (j) (4).

Noncovered Services for Dental Hygienists

Unless the service is part of a dental assessment and evaluation for a member under 21 years of age or is found necessary as a result of such an assessment and evaluation, the following services are not covered by BadgerCare Plus whether or not the service is performed by a person under the supervision of a dentist or physician or by a dental hygienist who is individually certified under ch. DHS 105:

1. Services performed outside the scope of practice of dental hygiene as defined under ss. 447.01(3) and s. 447.06, Wis. Stats.
2. Oral hygiene instruction or training in preventive dental care as a separate procedure, including tooth brushing technique, flossing or use of special oral hygiene aids, tobacco cessation counseling, or nutritional counseling.
3. General services for purely aesthetic or cosmetic purposes.

In certain unusual circumstances, the DHS (Department of Health Services) may request that a noncovered service be performed, including but not limited to diagnostic casts, in order to substantiate a PA (prior authorization) request. In these cases the service shall be reimbursed.

For dental hygienists, all services except prophylaxis, fluoride, and sealants are noncovered.

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Topic #2911

Education in Preventive Care

Education of a BadgerCare Plus member in preventive care and the provision of dental health information is a component of all allowable dental services covered by BadgerCare Plus, whenever appropriate. When provided, preventive training and information sharing should be documented in the member's dental records. These services are not reimbursed separately by Wisconsin Medicaid.

Infection Control Charges

Providers should note that all (OSHA) (Occupational Safety and Health Administration)-mandated and other infection-control charges are included in Medicaid reimbursement. These costs may not be separately reimbursed or charged to the member.

Take-Home Supplies

Routine take-home supplies (e.g., gauze) are not separately reimbursable. Wisconsin Medicaid reimbursement of dental procedures includes routine take-home supplies needed before or after the procedure is performed. Members may not be charged for routine supplies.

Resources

10

Archive Date:01/03/2012

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

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 (prior authorization) requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the 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 (Provider Electronic Solutions) 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.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN (Social Security number).

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 (National Provider Identifier) 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 (date of service).

Topic #474

Provider Services

Providers should call Provider Services to answer enrollment, policy, and billing questions. Members should call Member Services for information. Members should *not* be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services call center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submissions.
- Certification.
- COB (coordination of benefits) (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.
- PA (prior authorization) status.

- Verifying covered services.

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID.
- Member name and member identification number.
- Claim number.
- PA number.
- DOS (dates of service).
- Amount billed.
- RA (Remittance Advice).
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center 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 (Specialized Transmission Approval Technology-Prior Authorization) for STAT-PA inquiries, including inquiries from pharmacies, DME (durable medical equipment) 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 (end-stage renal disease), and hospice services or NIP (nurses in independent practice)).
- 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 (F-1170 (07/09)) 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.

Topic #475

Provider Suggestions

The DHCAA (Division of Health Care Access and Accountability) 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 (F-1016 (02/09)) form.

Topic #4456

Resources Reference Guide

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

Provider Services and Resources

Services and resources, contact information, and hours of availability are effective after ForwardHealth implementation, unless otherwise noted.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)***
For providers, trading partners, billing services, and clearing houses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		

* With the exception of state-observed holidays.

Electronic Data Interchange

Topic #11907

5010 Companion Guides and NCPDP Version D.0 Payer Sheet

The HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 version 5010 companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal for the following transactions:

- 270/271 Health Care Eligibility/Benefit Inquiry and Information Response.
- 276/277 Health Care Claim Status Request and Response.
- 278 Health Care Services Review — Request for Review and Response.
- 835 Health Care Claim Payment/Advice.
- 837 Health Care Claim: Professional.
- 837 Health Care Claim: Institutional.
- 837 Health Care Claim: Dental.
- 999 Functional Acknowledgment. (*Note:* The 999 replaced the 997 Functional Acknowledgment.)
- TA1 Interchange Acknowledgment.
- NCPDP version D.0.

The 5010 companion guides and the payer sheet completely replace the companion documents used for version 4010 and NCPDP version 5.1. The first issuance of the new companion guides does not include the summary of changes known as the "revision log." The first issuance of the payer sheet does not list revisions in Appendix A. Subsequent revisions to companion guides and the payer sheet will be documented.

The companion guides and the payer sheet provide ForwardHealth-specific information that should be used with the national HIPAA Implementation Guides. Implementation Guides define the national data standards, electronic format, and values required for each data element within an electronic transaction.

To request paper copies of the companion guides or the payer sheet, providers may contact Provider Services.

Compliance Testing

Each HIPAA-covered entity (i.e., provider, payer, clearinghouse, or other vendor) is responsible for ensuring its own compliance with versions 5010 and D.0 transaction requirements. Providers who contract with billing services, clearinghouses, or other vendors are responsible for ensuring the services provided by their contractors are compliant with HIPAA and ForwardHealth requirements.

After completing internal testing, covered entities are required to complete compliance testing with ForwardHealth to ensure that they are able to submit and receive versions 5010 and D.0 transactions and have identified and resolved all issues prior to the January 1, 2012, implementation date.

Version 5010

Prior to submitting version 5010-compliant electronic transactions to the ForwardHealth production environment, trading partners

are required to:

- Update their Trading Partner Profile on the Portal and agree to the revised Trading Partner Agreement.
- Complete compliance testing procedures as outlined in their 5010 Standard Testing Packet, found on the HIPAA Version 5010 and NCPDP Version D.0 Electronic Transaction Standards page of the Portal.

Trading partners may currently conduct compliance testing, except for the 278 (278 Health Care Services Review — Request for Review and Response) transaction, a new standard electronic format for health care service PA (prior authorization) requests. Trading partners may start compliance testing for the 278 transaction on January 1, 2012. After receiving an "accepted" 999 Functional Acknowledgement for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Version D.0

Providers may work with their VAN (Value Added Network) to complete any testing for version D.0 transactions; there will not be any direct testing between providers and ForwardHealth. Providers should contact their VAN or switch vendor for information or questions they may have regarding version D.0 preparedness.

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Documents

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA 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 (Remittance Advice), and enrollment inquiries).

Companion guides and payer sheet do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation).
- Transaction administration (e.g., tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk.

- Transaction formats.

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 version 5010 companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal. The 5010 companion guides replaced the companion documents used for version 4010 and the D.0 payer sheet replaced the companion document for NCPDP version 5.1.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response). The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review - Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Functional Acknowledgment). The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 InterChange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Functional Acknowledgment) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid 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.

Topic #469

An Overview

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

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

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Vendors sell magnetic stripe card readers, personal computer software, Internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the Internet.

Topic #4903

Copayment Information

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt 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, Medicaid, or SeniorCare and is required to pay a copayment, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

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.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should *always* verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR (Automated Voice Response) system.
- Commercial enrollment verification vendors.
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions.
- Provider Services.

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

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

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

Topic #4900

Entering Dates of Service

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

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

- The "From" DOS is the earliest date the provider requires enrollment information.
- The "To" DOS must be within 365 days of the "From" DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

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

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a "0" at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when 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 (date of service) that services are provided:

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

Topic #4898

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under 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 (Tuberculosis-Related Services Only) Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) 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.

Topic #766

Telephone or Mail Requests

Providers who do not have Internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

  ForwardHealth
  Form Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

Portal

Topic #11057

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

ForwardHealth has established a page on the ForwardHealth Portal designed to keep providers and trading partners informed of important dates and information related to the implementation of the new HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC X12 version 5010 and NCPDP (National Council for Prescription Drug Programs) telecommunication standard version D.0. Providers, trading partners, partners, MCOs (managed care organizations), and other interested parties are encouraged to check the 5010 page of the Portal often, as ForwardHealth will post new information regularly.

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

- Questions and answers about the transition to the new standards.
- Companion guides and payer sheet for the new standards.
- External compliance testing schedule and procedures.
- Links to national resources for version 5010 and version D.0 transactions.

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (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 (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Recertification Via the ForwardHealth Portal

Providers can conduct recertification online via a secure recertification area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care

Organizations

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

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN (personal identification number) 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 ForeardHealth 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.

Refer to the Account User Guide on the Portal User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #4910

Demographic Maintenance on the Portal

Dental providers will be able to indicate whether they are accepting new patients, not accepting new patients, or accepting new patients with limitations in the provider directory beginning after implementation of ForwardHealth interChange. Providers must first establish a provider account on the Portal.

To indicate if the dentist limits their practice, the provider should do the following:

- Go to the Portal.
- Log in to his or her provider account.
- Once logged in, the provider should click on the "demographic maintenance" link.
- Click on the "accepting new patients" link.

Select yes, no, or limited in the field "Are you accepting new patients at this time?"

If the provider selects "limited," the provider will be able to select one or more of the following options to limit services provided to members:

- Dentures only.
- Emergency only.
- Nursing home only.
- Oral surgery only.
- Provider home and surrounding counties only.
- Provider home county only.
- Root canal only.
- Children.

Providers may limit the number of Medicaid and BadgerCare Plus members in any number of ways, including based on certain demographic information, to certain days of the week, or times of the day. However, providers are prohibited from limiting their acceptance of Medicaid and BadgerCare Plus members in a way that discriminates against a protected class, as defined in federal and state anti-discrimination laws.

The option to indicate practice limits through the Portal is available to dental providers and members as a convenience. Not selecting one of the above option in no way limits a provider's ability to limit their practice in other acceptable ways.

Dentists may also update other provider information, such as address and telephone numbers, that displays in the provider directory. This can be done on the demographic maintenance page of the Portal.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

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

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

- 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 (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (08/08)) form.

Topic #5087

Electronic Communications

The secure ForwardHealth 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.

Topic #5088

Enrollment Verification

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

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

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

The Portal has the following areas:

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

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

Topic #4441

ForwardHealth Portal Helpdesk

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

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (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.

Topic #4400

Internet Connection Speed

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

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

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

Topic #4351

Logging in to the Provider Area of the Portal

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

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO (managed care organization) 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 (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, taxonomy code (if applicable), and provider type and specialty.

- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Topic #5158

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

Topic #4744

Members ForwardHealth Portal

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

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for 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 (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click 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 (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

        The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
        - SSI (Supplemental Security Income).
        - WCDP (Wisconsin Chronic Disease Program).
        - The WWWP (Wisconsin Well Woman Program).

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

Topic #4459

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP (Wisconsin Chronic Disease Program) 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.)

Topic #5089

Other Business Enhancements Available on the Portal

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

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different

business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

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

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

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

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

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, 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.

Topic #4912

Portal Clerk Administrators

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

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

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their 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).

Topic #4740

Public Area of the Provider Portal

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

Maximum Allowable Fee Schedules

Within the Portal, all maximum allowable fee schedules for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), 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 policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

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 (application tracking number) 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 (prior authorization).
- E-mail subscription service for *Updates*. Providers can register for e-mail subscription 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.

Topic #4741

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers 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 (Direct Data Entry) 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 (managed care organization).
- 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 (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

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

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

Topic #4401

System and Browser Requirements

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

Recommended System Requirements	**Recommended Browser Requirements**
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	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	

Topic #4742

Trading Partner Portal

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

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES (Provider Electronic Solutions) software and upgrade information.
- EDI (Electronic Data Interchange) companion guides.

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

Trading partners using PES should be sure to enter the Web logon and Web password associated with the ForwardHealth trading partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure Trading Partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

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

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

Online (Real-Time, Web-Based) Sessions

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

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

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

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

Recorded Webcasts

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

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

Notification of Training Opportunities

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

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

Updates

Topic #4460

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling Provider Services.

Topic #478

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA (prior authorization) submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is posted to the ForwardHealth Portal on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account are notified through their Portal message box when the *Update Summary* is available on the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may access Updates from direct links in the electronic *Update Summary* as well as navigate to other Medicaid iinformation 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 in conjunction with published *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

Topic #4458

Multiple Ways to Access ForwardHealth Publications

Users may register for 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.

E-mail Subscription Service

Providers and other interested parties may register for e-mail subscription 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 (Wisconsin Chronic Disease Program)) and provider type (e.g., physician, hospital, DME (durable medical equipment) 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.

Users may sign up for an e-mail subscription by following these steps:

1. Click the Providers link on the ForwardHealth Portal at www.forwardhealth.wi.gov/.
2. In the Quick Links section on the right side of the screen, click Register for E-mail Subscription.
3. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.
4. Enter the e-mail address again in the Confirm E-Mail field.
5. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
6. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
7. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
8. When service area selection is complete, click Save at the bottom of the page.
9. The selected subscriptions will load and a confirmation message will appear at the top of the page.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with touch-tone telephones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County Code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers (that exists on the DOS or within the DOS range selected), will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare 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.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (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.

Topic #466

Information Available Via WiCall

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

- Claim status.
- Enrollment verification.
- PA (prior authorization) status.
- Provider CheckWrite information.

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

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

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

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

Claim Status

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

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

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

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

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 (National Drug Code), procedure code, revenue code, or ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) 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.

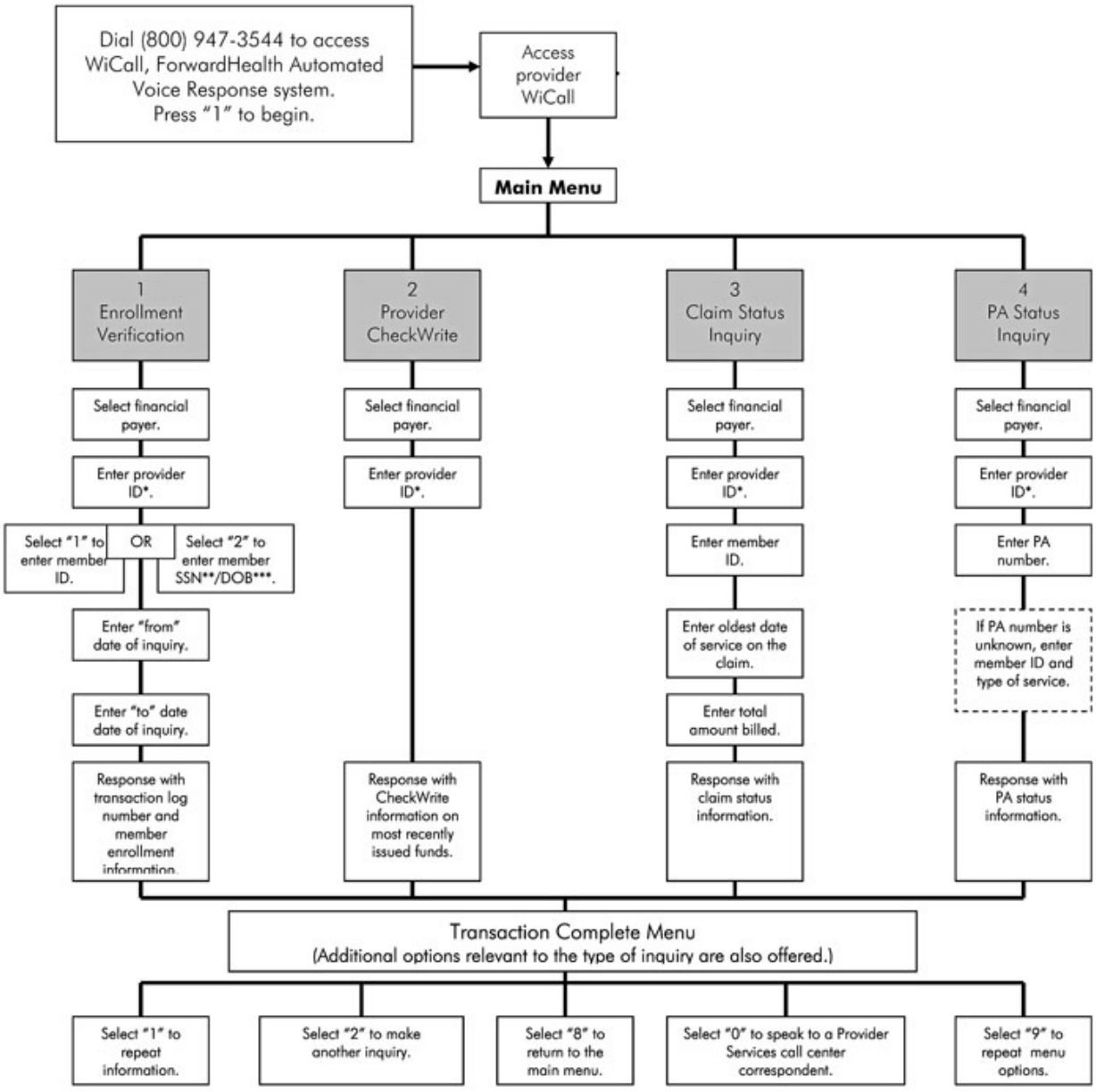
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth