wisconsin Medicaid update
and BadgerCare

January 2000
PHC 1698

Wisconsin Medicaid and BadgerCare Information for Providers

Family Care begins in February of 2000

On February 1, 2000, Family Care, a voluntary long term managed care program, will begin in Fond du Lac County. The State will contract with Care Management Organizations (CMOs) that will provide or arrange for services in the Family Care benefit. Each CMO will develop a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. Only providers affiliated with the CMO will receive reimbursement for providing services in the Family Care benefit package to recipients enrolled in that CMO.

"Creative Care Options of Fond du Lac County" is the CMO that will serve Family Care recipients in Fond du Lac County. Later in 2000, Family Care will expand to Milwaukee, Portage, Richland and La Crosse counties. Four additional Family Care pilots are planned to start in 2001.

For more information on the pilot county CMOs, contact the appropriate CMO at the following numbers:

- Fond du Lac: Creative Care Options of Fond du Lac County, (920) 929-6885.
- La Crosse: La Crosse County Care Management Organization, Network Developer, (608) 785-6054.
- Milwaukee: Supportive Options for Seniors, Member Relations, (414) 289-6857.
- Portage: Community Care of Portage County, Network Development Manager, (715) 345-5978.
- Richland: Aging and Disability Services of Richland County, Provider Network Developer, (608) 647-2302.

Family Care eligibility groups

In general, Family Care pilots will initially cover Medicaid recipients with long term care needs who are:

- Elderly.
- Adults with physical disabilities.
- Adults with developmental disabilities.

Functional eligibility for Family Care will be based on the degree to which a recipient can independently manage the everyday activities of living, such as moving around, eating, bathing, and dressing. Fond du Lac County's Family Care program will serve all three populations; however, recipient groups served may vary in other pilot counties.

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Eligibility verification

Since recipients can enroll in, or disenroll from, a Family Care CMO at any time during the month, providers should *always* check recipient eligibility for Family Care enrollment *before* providing services.

Providers may verify eligibility and enrollment in a Family Care CMO via the following resources:

- Automated Voice Response at (800) 947-3544 or (608) 221-4247.
- Provider Services at (800) 947-9627 or (608) 221-9883.
- Magnetic stripe reader (also known as a point-of-service device or terminal) or personal computer software. Card readers and software are available for purchase from commercial eligibility verification vendors.
- Direct Information Access Line with Updates for Providers (DIAL-UP) at (608) 221-4746.

  (For more information on these resources, refer to the September 1999 *Medicaid Update*.)

Providers and Care Management Organizations

Providers are required to contract with the CMO to continue providing Medicaid-covered services included in the Family Care benefit package to Family Care recipients. Providers that do not contract with a CMO may, under certain circumstances and with CMO prior authorization, provide services to Family Care recipients.

Care Management Organization authorization

The CMO is responsible for authorizing the Medicaid-covered services in the Family Care benefit package. All services in the Family Care benefit package must be authorized by the CMO before the services are provided. Providers will not receive reimbursement for services in the Family Care benefit package if they do not obtain CMO authorization prior to providing the services. Providers should contact the CMO *prior* to providing any of the services included in the Family Care benefit package. Providers should contact the CMO for information on the process for authorization, billing, and payment for services included in the Family Care benefit package.

Providers are required to contract with the CMO to continue providing Medicaid-covered services included in the Family Care benefit package to Family Care recipients.

Existing Medicaid prior authorization

Existing Medicaid prior authorization for services included in the Family Care benefit package will not be applicable when a recipient enrolls in Family Care. Providers are required to obtain prior authorization from the CMO to provide services included in the Family Care benefit package.

Medicaid services included in and excluded from the Family Care benefit package

In general, long term care services (for example, home health care services) are included in the Family Care benefit package. Acute and primary care services, including physician services, are not included in the Family Care benefit package and will remain fee-for-service. Please refer to Attachment 1 of this Update for a more comprehensive list of covered and noncovered services in the Family Care benefit package.✦

Pregnant women benefit from Presumptive Eligibility

Wisconsin Medicaid encourages qualified providers to become certified to make Presumptive Eligibility (PE) determinations for pregnant women who do not have health insurance. Presumptive Eligibility determinations assure that providers are reimbursed for necessary pregnancy-related prenatal care provided to pregnant women. This Update explains what Presumptive Eligibility is, how to file claims, and how to become a qualified Presumptive Eligibility provider.

What is Presumptive Eligibility?

Presumptive Eligibility (PE) is a Medicaid eligibility category that can allow an uninsured pregnant woman to receive immediate pregnancy-related outpatient services while her application for Wisconsin Medicaid is being processed.

Presumptive Medicaid Eligibility determinations are made based on pregnancy and income eligibility only; there is no asset test for Presumptive Eligibility.

Who is eligible?

To be eligible for Presumptive Eligibility, a woman must meet the all of the following criteria:

- Her pregnancy must be medically verified (pregnancy test).
- Her family's gross income cannot exceed 185% of the federal poverty level.

Presumptive Medicaid Eligibility determinations are made based on pregnancy and income eligibility only; there is no asset test for Presumptive Eligibility.

Presumptive Medicaid Eligibility can begin on the day on which a qualified provider determines whether the woman meets the criteria listed above by completing a Presumptive Eligibility Application (form DOH 1043). Upon completion, the provider should submit the application to Wisconsin Medicaid within five (5) days. A certified Medicaid provider can obtain blank application forms and instructions by contacting Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Once Wisconsin Medicaid receives the application from the certifying agency, a woman's eligibility for regular Medicaid is established on Medicaid's computer system within 48 hours.

Included with the Presumptive Eligibility application is a *beige* ID card that is given by the qualified provider to the woman on a temporary basis until she is determined eligible for Wisconsin Medicaid. A woman can be eligible for Presumptive Eligibility from the date the qualified provider determines a woman is eligible through the end of the following month. The provider making the Presumptive Eligibility determination is required to indicate the dates of eligibility on this card. The beige ID card identifies a woman as eligible for Presumptive Eligibility, and providers should accept it for the dates indicated on the card as proof of eligibility, even though eligibility will not be on Wisconsin Medicaid's file for 48 hours after the completed application is received.

What services are covered under Presumptive Eligibility?

Under Presumptive Eligibility, pregnant women are eligible to receive all covered pregnancy-related outpatient services (including dental services). All Medicaid-certified outpatient providers can provide these services to women covered under Presumptive Eligibility. Inpatient

services are not covered under Presumptive Eligibility. (Generally, eligibility for Medicaid is determined by the time of delivery.)

Services covered under Presumptive Eligibility and provided before regular eligibility is determined are reimbursed fee-for-service.

How do I get reimbursed for services covered under Presumptive Eligibility?

If a provider performs services for a woman eligible under the Presumptive Eligibility category, her eligibility information may not yet be available through Medicaid's Eligibility Verification System (EVS). To avoid delays in reimbursement, providers who provide Presumptive Eligibility services to a woman before her Medicaid eligibility can be verified should:

- Make a photocopy of the temporary beige Presumptive Eligibility ID card and submit it with the claim for Presumptive Eligibility covered services; or
- Wait until eligibility has been verified through EVS then submit a claim.

Wisconsin Medicaid encourages providers to always make a photocopy of the beige ID card for their records.

When billing Wisconsin Medicaid, the provider is required to indicate, by use of an appropriate diagnosis code, that the outpatient services are related to pregnancy:

Code	Description
V22.0 – V22.2	Normal pregnancy
V23.0 – V23.9	Supervision of high-risk pregnancy
V28.0 – V28.9	Antenatal screening
V72.4	Pregnancy examination or test, pregnancy unconfirmed
614 – 677	Inflammatory disease of female pelvic organs; other disorders of female genital tract; complications of pregnancy, childbirth, and the puerperium
760 – 763.9	Maternal causes of perinatal morbidity and mortality

Note: These diagnosis codes are not necessary when providers bill for:

- Dental services (billed on ADA or HCFA 1500 claim form).
- Laboratory services.
- Radiology services.
- Services billed on drug claim form.

How long does Presumptive Eligibility last?

Because Presumptive Eligibility is temporary eligibility for pregnancy-related outpatient services only, a pregnant woman should be advised to apply for Wisconsin Medicaid while receiving Presumptive Eligibility services. (Women found eligible for Medicaid will receive a Forward ID card.)

Because Presumptive Eligibility is temporary eligibility for pregnancy-related outpatient services only, a pregnant woman should be advised to apply for Wisconsin Medicaid while receiving Presumptive Eligibility services.

A woman covered under Presumptive Eligibility may receive services beginning on the "from" date of the beige card, and extending through the "thru" date of the card or the "PE Extension" date if an extension has been granted by a county or tribal certifying agency. The period of Presumptive Eligibility coverage ends on the earliest of *either*:

- The day on which a recipient's Medicaid eligibility is determined by the county or tribal certifying agency.
- The end of the month following the month in which a recipient is determined eligible

by the qualified provider, if she does not apply for Medicaid or is determined not to be eligible for Medicaid.

What criteria do I have to meet to be qualified to determine Presumptive Eligibility?

You may become qualified to make Presumptive Eligibility determinations if you meet the following state and federal requirements:

State Criteria:

- Must be a currently certified Wisconsin Medicaid provider; and
- Must have submitted an application for certification to the Division of Health Care Financing (DHCF).

Federal Criteria:

- Must provide services typically provided by one of the following:
  - Clinics furnished by or under the direction of a physician (§1905(a)(9) of the Social Security Act); or
  - Outpatient hospitals (§1905(a)(a)(A) of the Social Security Act); or
  - Rural health clinics (§1905(a)(2)(B) of the Social Security Act).

AND, either the provider participates in a program established under one of the following:

- A state perinatal program defined as a physician, nurse practitioner, certified nurse-midwife, family planning clinic, outpatient hospital, or other clinic that provides prenatal medical care to Wisconsin Medicaid recipients; or
- The Indian Health Services, or is a health program or facility operated by a tribe or tribal organization (the Indian Self-Determination Act – Public Law 93-638); or
- The Women, Infants, and Children Supplemental Nutrition Program (WIC) (§17 of the Child Nutrition Act of 1966); or
- The Commodity Supplemental Food Program (§4(a) of the Agriculture and Consumer Protection Act of 1973).

OR the provider receives funds under one of the following:

- The Community Health Centers or Migrant Health Centers (§330 or 329 of the Public Health Act); or
- The Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act); or
- Title V of the Indian Health Care Improvement Act.

Where may I obtain an application to become a qualified Presumptive Eligibility provider?

To receive an application to become a qualified Presumptive Eligibility provider, please contact Provider Services at (800) 947-9627 or (608) 221-9883.

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More information

For more information about Presumptive Eligibility, please refer to Section V of Part A, the all-provider handbook, or to Section I of Part Z, the prenatal care coordination services handbook.✦

Automated Voice Response system helpful hints

The Automated Voice Response (AVR) system is one way providers can access Medicaid's Eligibility Verification System. Call (800) 947-3544 or (608) 221-4247 (Madison area) to connect with AVR. It is available 24 hours a day, seven days a week.

Tips for using the Automated Voice Response system more efficiently

Providers may use the Automated Voice Response (AVR) system to obtain recipient eligibility information, checkwrite information, claim status information, and prior authorization status information. The following tips will help you use AVR efficiently.

Dates of service

- If you want eligibility information about a previous date *and* the current date, two inquiries are often better than one. If you make one inquiry for a range of dates, you will receive eligibility information for months which may not be of interest to you.
- As a shortcut, press "#" at the prompt for today's date instead of entering "MMDDYYYY" format and press "#" if TO and FROM dates are the same.
- Keep in mind that generally you cannot request eligibility information for future dates. However, if you verify eligibility for the current date which is after the 20th of the month, eligibility status for the current month and the following month will be given.
- Providers may access eligibility information for a range of dates up to 365 days in the past through the current date.

Verify eligibility before appointments

- Providers can obtain eligibility information for the current month and the following month if they verify it after the 20th of the current month.
- Providers should use AVR to find out whether a recipient is enrolled in a Medicaid HMO or special managed care program. Keep in mind that HMO enrollment may change during the month.
- Commercial insurance information can change at any time. You may want to verify eligibility prior to billing in case the recipient's commercial insurance information has changed since the appointment.

Further assistance

Some inquiries may require assistance from a correspondent in Provider Services. Provider Services correspondents can give you the following information:

- Recipient eligibility (including eligibility information beyond 365 days in the past).
- Provider certification.

Correspondents are available to help you at the following times:

- Monday, Wednesday, Thursday, and Friday from 8:30 a.m. to 4:30 p.m.
- Tuesdays from 9:30 a.m. to 4:30 p.m.

You can reach Provider Services during business hours from AVR by pressing "0" at any time during the call or by hanging up and calling (800) 947-9627 or (608) 221-9883.

The Automated Voice Response (AVR) system is one way providers can access Medicaid's Eligibility Verification System.

Please refer to Attachment 2 for an *optional* form providers may find helpful for recording information from the AVR system.

Use optional form provided to record Automated Voice Response information

Please refer to Attachment 2 for an *optional* form providers may find helpful for recording information from the AVR system. The form is divided into the AVR information categories:

- Recipient Eligibility Information.
- Provider Checkwrite Information.
- Claim Status Information.
- Prior Authorization Information.

This form is not only helpful for recording information from the AVR system, but it is also helpful to organize the information that you'll need when you call the AVR system.

Listen to full message

Make sure you listen to the full AVR response message before hanging up so you are sure to receive all of the information.✦

What's new on the Medicaid web site

The Wisconsin Medicaid web site includes provider and recipient publications, Medicaid contacts and statistics, and eligibility and benefit information. The following is a list of what has recently been added to the Medicaid web site.

You may visit the Medicaid web site at *www.dhfs.state.wi.us/medicaid/*.

- January 2000 *Medicaid Update*.
- Updated caseload statistics. These statistics include the number of eligible individuals who may receive Medicaid services and BadgerCare enrollment by category.

Keep in mind that if you do not have a computer with Internet access, many schools and libraries have access.✦

The *Wisconsin Medicaid Update* is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our web site at *www.dhfs.state.wi.us/medicaid/*.

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Attachment 1
Medicaid Services Included/Not Included in the Family Care Benefit Package

Medicaid Services Included in the Family Care Benefit Package

The following Medicaid-covered services are available through the Family Care CMOs.

- ***Case Management*** - provided by case management agencies.
  - ✓ Except Discharge Planning provided in a hospital inpatient setting.

- ***Home Care Services*** - provided by home health agencies, personal care agencies, independent nurses, and respiratory therapists.
  - ✓ Home health aide services.
  - ✓ Personal care.
  - ✓ Skilled nursing (including independent nursing services).
    - Intermittent (less than 8 hours per day).
    - Private duty nursing (8 or more hours per day).
    - Respiratory care.
  - ✓ Occupational and physical therapy, and speech and language pathology services *(see Therapy Services below*).

- ***Mental Health/Substance Abuse and Related Services*** - provided by mental health providers, substance abuse (alcohol and other drug abuse) treatment providers, day treatment programs, community support programs.
  - ✓ Mental health and substance abuse (alcohol and other drug abuse) services.
    - Except those services provided by a physician.
    - Except those services provided in an inpatient hospital setting.
  - ✓ Day treatment (mental health and substance abuse).
  - ✓ Child/adolescent mental health day treatment.
  - ✓ Community Support Program services.
    - Except when provided by a physician.
    - Except non-psychiatric medication and treatment services.
  - ✓ In-home intensive psychotherapy.
  - ✓ In-home autism treatment.

- ***Nursing Facilities*** – all nursing facility stays (including Intermediate Care Facility for People with Mental Retardation [ICF/MR] and Institution for Mental Disease [IMD]).
  - ✓ Except lab and radiology ancillary services.

- ***Supplies and Equipment*** - provided by any provider.
  - ✓ Disposable medical supplies.
    - Except supplies used in a hospital or physician clinic.
  - ✓ Durable medical equipment (DME) purchased or rented in all settings.
    - Except for hearing aids, hearing aid accessories, hearing aid batteries, and assistive listening devices.
    - Except for prosthetics.
  - ✓ Repair and maintenance of DME.
    - Except for repair and maintenance of hearing aids and assistive listening devices.
    - Except for repair and maintenance of prosthetics.
  - ✓ Orthotics (purchase and repair).

- ***Therapy Services*** - provided by therapy and speech and language providers.
  - ✓ Occupational therapy.
    - Except those services provided by physicians in clinic settings.
    - Except those services provided in an inpatient hospital setting.
  - ✓ Physical therapy.
    - Except those services provided by physicians in clinic settings.
    - Except those services provided in an inpatient hospital setting.
  - ✓ Speech and language pathology services.
    - Except those services provided by physicians in clinic settings.
    - Except those services provided in an inpatient hospital setting.

- ***Transportation*** - provided by specialized medical vehicle providers.

Medicaid Services Not Included in the Family Care Benefit Package

The following Medicaid services are not included in the Family Care benefit package. Providers and counties should continue to bill these services to Wisconsin Medicaid for Medicaid-eligible Family Care recipients.

- Alcohol and other drug abuse services provided by a physician or provided in an inpatient hospital setting.
- Ambulance transportation.
- Audiology.
- Chiropractic.
- Crisis intervention services.
- Dentistry.
- Eyeglasses.
- Family planning services.
- Hearing aids (including batteries, accessories, and assistive listening devices, and repair and maintenance of hearing aids and assistive listening devices).
- Hospice.
- Hospital: Inpatient (except DME).
- Hospital: Outpatient (except physical therapy, occupational therapy, speech and language pathology, mental health services, and substance abuse [alcohol and other drug abuse] treatment).
- Independent nurse practitioner services.
- Lab and X-ray.
- Mental health services provided by a physician or provided in an inpatient hospital setting.
- Nurse midwife services.
- Optometry.
- Pharmaceuticals.
- Physician services.
- Podiatry.
- Prenatal care coordination.
- Prosthetics (including repair and maintenance).
- School-based services.
- Transportation by common carrier (the billing method for this service remains unchanged).

ATTACHMENT 2
AUTOMATED VOICE RESPONSE SYSTEM INFORMATION SHEET
(for optional use)

(800) 947-3544 or **(608) 221-4247**

Today's date:____________________

AVR Main Menu

"**1**" Recipient eligibility verification information
"**2**" Provider checkwrite information
"**3**" Claim status inquiry
"**4**" Prior authorization status inquiry

RECIPIENT ELIGIBILITY VERIFICATION INFORMATION (Certain categories may not be applicable to all recipients.)

1. Provider number	*2. Recipient ID number or Date of Birth "MMDDYYYY" and SSN*
3. FROM - date of service ("#" for today's date or 8-digit date "MMDDYYYY")	*4. TO - date of service ("#" for same date or 8-digit date)*
5. Transaction verification number **V** ___ ___ ___ ___ ___	6. Date of birth
7. Eligibility dates FROM: TO:	8. County code

9. SPECIAL ELIGIBILITY RESPONSES

BadgerCare:_____

QMB (limited coverage):_____

TB-related services:_____

Presumptive eligibility:_____

Emergency services:_____

Health personnel shortage area:_____

Enrolled in state managed care prog.? NO YES MCP code_____

- Name of program:
- Telephone number:
- Covers: Chiropractic_____ Dental_____

Medicare coverage:

- Coverage: Part A_____ Part B_____
- Medicare number -

Other insurance:

- Coverage indicator -

Lock-In information:

- From (date) -
- To (date) -
- Services -

10. OTHER COMMERCIAL HEALTH INSURANCE:

From (date) -	From (date) -	From (date) -	From (date) -
To (date) -	To (date) -	To (date) -	To (date) -
Med____ Den____ Pharm____	Med____ Den____ Pharm____	Med____ Den____ Pharm____	Med____ Den____ Pharm____
Carrier name -	Carrier name -	Carrier name -	Carrier name -
Address -	Address -	Address -	Address -
Telephone number -	Telephone number -	Telephone number -	Telephone number -
Coverage indicator -	Coverage indicator -	Coverage indicator -	Coverage indicator -
Policyholder's SSN -	Policyholder's SSN -	Policyholder's SSN -	Policyholder's SSN -
Relationship to insured -	Relationship to insured -	Relationship to insured -	Relationship to insured -
Policy number -	Policy number -	Policy number -	Policy number -
Group number -	Group number -	Group number -	Group number -

To repeat eligibility information for recipient – press "**8**"

To make another eligibility inquiry – press "**1**"

To return to AVR main menu – press "**9**"

To receive assistance from a correspondent – press "**0**"

Items in italics indicate information providers need before calling.

PROVIDER CHECKWRITE INFORMATION

1. Provider number	2. Check amount	3. Date of check

To repeat checkwrite information – press "**8**"
To make another checkwrite inquiry – press "**2**"
To return to AVR main menu – press "**9**"
To receive assistance from a correspondent – press "**0**"

CLAIM STATUS INFORMATION

1. Billing provider number	*2. Recipient ID number*	*3. Oldest date of service on claim (MMDDYYYY)*
4. Total billed ($125.00 = 12500)		
IF PAID: Claim paid date -	Claim paid amount -	
IF DENIED: Claim denied date -	R/S Report date -	
CLAIM IN PROCESS		

To repeat claim status information – press "**8**"
To make another claim status inquiry – press "**3**"
To return to AVR main menu – press "**9**"
To receive assistance from a correspondent – press "**0**"

PRIOR AUTHORIZATION REQUEST INFORMATION

1. Provider number	*2. PA number*	*3. Recipient's name*
APPROVED on (grant date): OR AMENDMENT PROCESSED on (date):	Letter mailed on (date):	
APPROVED WITH MODIFICATIONS (grant date): Returned on (date): OR Amendment processed on (date):		
DENIED ON (date): Retuned on (date): OR Amendment processed on (date):		
RETURNED (date):		
PENDING:		
AMENDED:		

To repeat prior authorization information – press "**8**"
To make another prior authorization inquiry – press "**4**"
To return to AVR main menu – press "**9**"
To receive assistance from a correspondent – press "**0**"

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