

Affected Programs: BadgerCare Plus, Medicaid

To: Family Planning Clinics, HMOs and Other Managed Care Programs

ForwardHealth Announces Changes to Paper and Electronic Claims Submission for Family Planning Services

This *ForwardHealth Update* announces changes to paper and electronic claim submission for family planning services, effective October 2008, with the implementation of the ForwardHealth interChange system and the adoption of National Provider Identifiers.

This *Update* includes a sample 1500 Health Insurance Claim Form (dated 08/05) and revised completion instructions and the revised Adjustment/Reconsideration Request, F-13046 (10/08), with completion instructions.

A separate *Update* will give providers a calendar of important dates related to implementation.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

Implementation of ForwardHealth interChange

In October 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS).

ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization requests through the secure ForwardHealth Portal. Refer to the March 2008

ForwardHealth Update (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to paper and electronic claims submission procedures that are detailed in this *Update*. These changes are not policy or coverage related.

Providers may use any of the following methods to submit claims after the October 2008 implementation of ForwardHealth interChange:

- Electronic, using one of the following:
 - ✓ Online claim submission through the ForwardHealth Portal. This is a **new** claim submission option available with the implementation of ForwardHealth interChange.
 - ✓ Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claim transaction submissions through Electronic Data Interchange.
 - ✓ Provider Electronic Solutions (PES) software.

- Paper, using the 1500 Health Insurance Claim Form (dated 08/05).

The PES software will be updated to accommodate changes due to ForwardHealth interChange and National Provider Identifier (NPI) implementation; a revision to the PES Manual will be furnished for PES users.

General Changes for Claims Submission

Unless otherwise indicated, the following information applies to both paper and electronic claims submission for providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

Note: Providers should only use these instructions for claims received following implementation of ForwardHealth interChange. Following these procedures prior to implementation will result in the claim being denied.

Revision of Good Faith Claims Process

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment file and the member's actual enrollment. If a member presents a temporary card or an Express Enrollment (EE) card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's Enrollment Verification System (EVS) indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to BadgerCare Plus. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related Explanation of Benefits code, providers should contact Provider Services at (800) 947-9627 for assistance.

Elimination of Series Billing

ForwardHealth will accept multi-page claims with as many as 50 details on a 1500 Health Insurance Claim

Form; therefore, series billing (i.e., allowing providers to indicate up to four DOS per detail line) is no longer necessary and will no longer be accepted. Claims submitted with series billing will be denied. Single and range dates on claims will be accepted.

Performing Provider Changing to Rendering Provider

ForwardHealth has adopted the HIPAA term "rendering provider" in place of "performing provider" to align with HIPAA terminology.

Provider Identifiers

The referring provider's NPI is required on claims. The claim will be denied if the referring provider's NPI is not indicated or if the NPI is invalid.

1500 Health Insurance Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the 1500 Health Insurance Claim Form (dated 08/05) with the instructions included in this *Update*. Claims received on the CMS 1500 claim form (dated 12/09) after implementation will be returned to the provider unprocessed.

Refer to Attachments 1 and 2 of this *Update* for completion instructions and a sample 1500 Health Insurance Claim Form for family planning services.

Note: Providers should only use these instructions for claims received following ForwardHealth interChange implementation. Following these procedures prior to implementation will result in the claim being denied.

Valid Diagnosis Codes Required

ForwardHealth will monitor claims submitted on the 1500 Health Insurance Claim Form for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use

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

Diagnosis Code Pointer Changes

ForwardHealth will accept up to eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To add additional diagnosis codes in this element, 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.

In Element 24E of the 1500 Health Insurance Claim Form, providers may indicate up to four diagnosis pointers per detail line. Valid diagnosis pointers are digits 1 through 8; digits should not be separated by commas or spaces. Services without a diagnosis pointer will be denied.

National Drug Codes Required on Claims for Outpatient Physician-Administered Drugs

Providers will be required to comply with requirements of the federal Deficit Reduction Act of 2005 (DRA) and submit National Drug Codes (NDCs) with Healthcare Common Procedure Coding System (HCPCS) and select *Current Procedural Terminology* (CPT) procedure codes on claims for outpatient physician-administered drugs. National Drug Codes should be indicated in the shaded area of Element 24A-F for all claims submitted for outpatient physician-administered drugs. The NDC information will be used to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal financial participation (FFP) funds. Claims will be denied if an NDC is not indicated or if the NDC indicated is incorrect or invalid.

If a provider dispenses a medication with a HCPCS or CPT procedure code that requires multiple NDCs (e.g., multiple package sizes), all of the NDCs must be indicated on the claim.

Watch for future publication for more information on NDCs for outpatient physician-administered drugs.

Indicating Quantities

When indicating days or units in Element 24G, only use a decimal when billing fractions; for example, enter “1.50” to indicate one and a half units. For whole units, simply enter the number; for example, enter “150” to indicate 150 units.

Signature and Date on Medicare Crossovers

A provider signature and date is now required on all provider-submitted claims, including all Medicare crossover claims submitted by providers on the 1500 Health Insurance Claim Form and processed after ForwardHealth interChange implementation. The words “signature on file” will no longer be acceptable. Provider-submitted crossover claims without a signature or date will be denied or be subject to recoupment.

Adjustment/Reconsideration Request Changes

Providers will be required to use the revised Adjustment/Reconsideration Request, F-13046 (10/08). The Adjustment/Reconsideration Request was revised to be able to be used by all ForwardHealth providers to request an adjustment of an allowed claim (a paid or partially paid claim). An adjustment or reconsideration request received in any other format will be returned to the provider unprocessed.

Refer to Attachments 3 and 4 for the revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

Information Regarding Managed Care

This Update contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

Providers are reminded that members are allowed to receive family planning services outside an HMO's provider network. In such cases, family planning services are reimbursed on a fee-for-service basis.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at dhs.wisconsin.gov/forwardhealth/.

P-1250

ATTACHMENT 1

1500 Health Insurance Claim Form Completion

Instructions for Family Planning Services

Effective for claims received on and after implementation of ForwardHealth interChange.

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

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for more information about verifying enrollment.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

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

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other

Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number

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

Element 2 — Patient's Name

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

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

Element 4 — Insured's Name

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

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 (not required)

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

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

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

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

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

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

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

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

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

Element 17 — Name of Referring Provider or Other Source

Enter the referring physician's name.

Element 17a (not required)

Element 17b — NPI

Enter the National Provider Identifier (NPI) of the referring physician.

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

Element 19 — Reserved for Local Use

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

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

Element 21 — Diagnosis or Nature of Illness or Injury

Enter a valid *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-24G (shaded area)

National Drug Codes (NDCs) must be indicated in the shaded area of Elements 24A-24G. Providers may indicate up to two NDCs per completed service line. Each NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier “N4,” followed by the 11-digit NDC, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between. The NDC units should be recorded with an implied decimal three digits from the left; for example, to indicate a unit of “1,” “1000” would be entered after the unit qualifier.
- If indicating two NDCs in a service line, separate the two “sets” of NDC data by three spaces.
- When submitting more than one NDC on a claim, providers are required to use Healthcare Common Procedure Coding System service code J3490.

For example, two NDCs indicated in the shaded area of Elements 24A-24G would look like:

N412345678912 GR123678 N498765432198 UN67000

Element 24A — Date(s) of Service

Enter to and from dates of service (DOS) in MM/DD/YY or MM/DD/CCYY 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 MM/DD/YY or MM/DD/CCYY format.

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

Element 24B — Place of Service

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

Element 24C — EMG

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

Element 24E — Diagnosis Pointer

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

Element 24F — \$ Charges

Enter the total charge for each line item.

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

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

Element 24G — Days or Units

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

Element 24H — EPSDT/Family Plan

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 (not required)**Element 24J — Rendering Provider ID. # (not required)****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 (not required)**Element 30 — Balance Due**

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

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

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

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

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

Element 32 — Service Facility Location Information (not required)**Element 32a — NPI (not required)****Element 32b (not required)****Element 33 — Billing Provider Info & Ph #**

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

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

Enter qualifier "ZZ" followed by the 10-digit provider taxonomy code.

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

ATTACHMENT 2

Sample 1500 Health Insurance Claim Form for Family Planning Services

1500										CARRIER			
HEALTH INSURANCE CLAIM FORM										PICA			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05													
1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP ☐ FECA ☐ OTHER ☐ (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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 M ☐ F ☒		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 ☐		CITY		STATE					
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		Employed ☐ Full-Time ☐ Student ☐ Part-Time ☐		ZIP CODE		TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO c. OTHER ACCIDENT? ☐ YES ☐ NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐		SEX							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐				b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
d. INSURANCE PLAN NAME OR PROGRAM NAME				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 0111111110		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		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V25.1 3. _____				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. ICD-9-CM I. ID. UICL J. RENDERING PROVIDER ID. #							
11 03 08 11 99213 1 XXXXX 1 Y NPI													
11 03 08 11 71010 26 1 XXXXX 1 Y NPI													
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES ☐ NO ☐		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$		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 MM/DD/YY				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # I.M. Provider 1 W Williams St Anytown WI 55555-1234							
SIGNED _____ DATE _____				a. NPI b. ZZ123456789X		a. 0222222220 b. ZZ123456789X							

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

ATTACHMENT 3

Adjustment/Reconsideration Request Completion Instructions

(A copy of the "Adjustment/Reconsideration Request Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

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

ForwardHealth members 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 eligibility status, accurate name, address, and member number (HFS 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 prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The Adjustment/Reconsideration Request, F-13046, is used by ForwardHealth to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627.

The Adjustment/Reconsideration Request is reviewed by ForwardHealth based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Providers should be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

The provider is required to maintain a copy of this form for his or her records.

The provider should mail the Adjustment/Reconsideration Request to the appropriate mailing address:

BadgerCare Plus
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

WCDP
PO Box 6410
Madison WI 53716-0410

WWWP
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

Type or print clearly. Enter the following information from the provider's Remittance Advice or the 835 Health Care Claim Payment/Advice (835) transaction.

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Check the appropriate box to indicate the applicable program to which the adjustment request is being submitted.

Element 1 — Name — Billing Provider

Enter the billing provider's name.

Element 2 — Billing Provider's Provider ID

Enter the Provider ID of the billing provider.

Element 3 — Name — Member

Enter the complete name of the member for whom payment was received.

Element 4 — Member Identification Number

Enter the member ID.

SECTION II — CLAIM INFORMATION (Non-Pharmacy)

Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

Element 6 — Internal Control Number / Payer Claim Control Number

Enter the internal control number (ICN) from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

Element 7 — Date(s) of Service

Enter to and from date(s) of service (DOS) in MM/DD/YY or MM/DD/CCYY 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 grouping services, the place of service, procedure code, charges, and rendering provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive dates. The number of days must correspond to the number of units in Element 24G of the 1500 Health Insurance Claim Form.

Element 8 — POS

Enter the appropriate two-digit POS code for each service.

Element 9 — Procedure / NDC / Revenue Code

Enter the single most appropriate procedure code. ForwardHealth will deny claims received without an appropriate procedure code, National Drug Code (NDC), or revenue code. When adjusting a detail that includes an NDC and a "J" code, providers are required to attach a paper claim form to the adjustment request and follow the claim form instructions for submitting the NDC.

Element 10 — Modifiers 1-4

Enter the appropriate modifier(s).

Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate 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 12 — Unit Quantity

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

Element 13 — Family Planning Indicator

Enter a "Y" for each family planning procedure when applicable.

Element 14 — EMG

Emergency Indicator. Enter a "Y" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank. Dental providers should continue to enter an "E" to indicate each procedure performed as an emergency.

Element 15 — Rendering Provider Number

Health care providers may enter their NPI and taxonomy code. Non-healthcare providers may enter their Provider ID.

SECTION II — CLAIM INFORMATION (Pharmacy)

Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

Element 6 — Internal Control Number / Payer Claim Control Number

Enter the ICN from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

Element 7 — Date(s) of Service

Enter the date filled in MM/DD/YY or MM/DD/CCYY format for each NDC in the "From" field.

Element 8 — POS

Enter the appropriate two-digit National Council for Prescription Drug Programs (NCPDP) patient location code for each NDC billed.

Element 9 — Procedure / NDC / Revenue Code

Enter the NDC. Claims received without an appropriate NDC will be denied.

Element 10 — Modifiers 1-4

Not applicable for pharmacy claims.

Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate 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 12 — Unit Quantity

Enter the metric decimal quantity in the specified unit of measure according to the ForwardHealth drug file. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

Element 13 — Family Planning Indicator

Not applicable for pharmacy claims.

Element 14 — EMG

Not applicable for pharmacy claims.

Element 15 — Rendering Provider Number

Not applicable for pharmacy claims.

SECTION III — ADJUSTMENT INFORMATION

Note: Additional information necessary for adjustment/reconsideration of an NDC should be included in Element 16 under "Other/comments."

Element 16 — Reason for Adjustment

Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the member was a nursing home resident on the DOS, the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Medicare remittance information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other / comments.* Add any clarifying information not included above.*

Element 17 — Signature — Billing Provider**

Authorized signature of the billing provider.

Element 18 — Date Signed**

Use either the MM/DD/YY format or the MM/DD/CCYY format.

Element 19 — Claim Form Attached

Indicate if a corrected claim form is attached. Although this is optional, ForwardHealth encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

* This section of the Adjustment/Reconsideration Request form should be used for any pharmacy-specific fields (e.g., prescription number) pertaining to the NDC being adjusted or added to a previously processed claim. If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.

** If the date or signature is missing on the Adjustment/Reconsideration Request form, the adjustment request will be denied.

ATTACHMENT 4

Adjustment/Reconsideration Request (for photocopying)

(A copy of the "Adjustment/Reconsideration Request" is located on the following page.)

FORWARDHEALTH
ADJUSTMENT / RECONSIDERATION REQUEST

Instructions: Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate applicable program.

☐ BadgerCare Plus / SeniorCare / Wisconsin Medicaid ☐ WCDP ☐ WWWP

1. Name — Billing Provider

2. Billing Provider's Provider ID

3. Name — Member

4. Member Identification Number

SECTION II — CLAIM INFORMATION

5. Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

6. Internal Control Number / Payer Claim Control Number

- ☐ Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).
☐ Correct detail on previously paid / allowed claim (in 7-12, enter information as it appears on Remittance Advice or 835).

7. Date(s) of Service		8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4				11. Billed Amount	12. Unit Quantity	13. Family Planning Indicator	14. EMG	15. Rendering Provider Number
From	To			Mod 1	Mod 2	Mod 3	Mod 4					

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment

- ☐ Consultant review requested.
☐ Recoup entire payment.
☐ Other insurance payment (OI-P) \$ _____.
☐ Copayment deducted in error ☐ Member in nursing home. ☐ Covered days _____. ☐ Emergency.
☐ Medicare reconsideration. (Attach the Medicare remittance information.)
☐ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
☐ Other / comments.

17. **SIGNATURE** — Billing Provider

18. Date Signed

Mail completed form to the applicable address:

BadgerCare Plus	WCDP	WWWP
Claims and Adjustments	PO Box 6410	PO Box 6645
6406 Bridge Rd	Madison WI 53716-0410	Madison WI 53716-0645
Madison WI 53784-0002		

19. Claim Form Attached (Optional)

☐ Yes ☐ No

Maintain a copy of this form for your records.

