ForwardHealth
Wisconsin serving you

Update
July 2008

No. 2008-104

Affected Programs: BadgerCare Plus, Medicaid
To: Hospice Providers, HMOs and Other Managed Care Programs

ForwardHealth Announces Changes to Paper and Electronic Claims Submission for Hospice Providers

This *ForwardHealth Update* announces changes to paper and electronic claims submission for hospice providers. These changes are effective October 2008, with the implementation of the ForwardHealth interChange system and the adoption of National Provider Identifiers.

This *Update* includes the following attachments:

- A sample UB-04 Claim Form for hospice services and revised completion instructions.
- Healthcare Common Procedure Coding System codes required for hospice claims.
- 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 UB-04 Claim Form.

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.

Elimination of M-5 Medicare Disclaimer Code

The ForwardHealth interChange system will be able to determine whether a provider is Medicare certified on the date of service (DOS). Therefore, Medicare disclaimer code "M-5" (Provider is not Medicare certified) has been eliminated. The only allowable Medicare disclaimer codes in the ForwardHealth interChange system will consist of "M-7" (Medicare disallowed or denied payment) and "M-8" (Noncovered Medicare service). Providers should note that if the "M-5" disclaimer code is indicated on the claim, the claim will be 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 999 details on a UB-04 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.

UB-04 Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the UB-04 Claim Form with the instructions included in this *Update.* Claims received on the UB-92 Claim Form after implementation will be returned to the provider unprocessed.

Refer to Attachments 1 and 2 of this *Update* for completion instructions and a sample UB-04 Claim Form for hospice 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.

Revenue Codes on UB-04 Claims

Providers are reminded that they are required to indicate a four-digit revenue code on UB-04 claims requiring a revenue code. Claims that have invalid revenue codes will be denied. Attachment 5 lists valid revenue codes for hospice services.

Healthcare Common Procedure Coding System Codes on UB-04 Claims

Providers will be required to indicate a valid Healthcare Common Procedure Coding System (HCPCS) code in addition to a revenue code on the UB-04 Claim Form. Attachment 5 lists each hospice revenue code and its corresponding HCPCS code. Providers should enter the appropriate HCPCS procedure code in Form Locator 44 on the same detail line as the matching revenue code.

Entering Dates on UB-04 Claims

Providers will be required to indicate a "To-From" period in Form Locator 6 using the MMDDYY format. Providers should enter the first day of the month (or the date of enrollment in hospice care) and the last day of the month (or the date of death or revocation of hospice care) in Form Locator 6.

For specific services billed on the claim form, providers should enter the "from" DOS in Form Locator 45 using the MMDDYY format and enter the "to" DOS in Form Locator 49 using the DD format. Providers should no longer enter dates in Form Locator 43.

Covered and Noncovered Days

Providers should indicate the number of days covered or noncovered by the primary payer in Form Locators 39-41 a-d. To indicate covered days, enter "80" in the value code field; for noncovered days, enter "81." The number of covered or noncovered days must be entered with two decimal places in the value codes amount field. For example, to indicate one day, providers must enter "1.00"; to enter 12 days, providers must enter "12.00." The total number of days in Form Locators 39-41 a-d must match the number of days indicated in the "From-Through" period in Form Locator 6.

Valid Diagnosis Codes Required

Providers are reminded that claims submitted on the UB-04 Claim Form will be monitored 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 will be denied.

Detail Quantity

Providers are required to enter a quantity in Form Locator 46. ForwardHealth will not assume a quantity of one if Form Locator 46 is left blank. If the detail quantity is missing in Form Locator 46 on UB-04 claims, the detail will deny.

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.

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
UB-04 (CMS 1450) Claim Form Completion Instructions for Hospice Services

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

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for ForwardHealth. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site at *www.nubc.org/*.

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. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about verifying enrollment.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

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

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, city, state, and ZIP+4 code. The name in Form Locator 1 should correspond with the National Provider Identifier (NPI) in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835) transaction.

Form Locator 3b — Med. Rec. # (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 — Type of Bill

Exclude the leading zero and enter the three-digit type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. Hospice providers should use bill types 81X (non-hospital-based hospice) or 82X (hospital-based hospice). The third digit ("X") indicates the billing frequency; providers should enter one of the following for "X":

- 1 = Admit through discharge claim.
- 2 = Interim — first claim.
- 3 = Interim — continuing claim.
- 4 = Interim — final claim.

Form Locator 5 — Fed. Tax No.

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. If computer software does not automatically complete this element, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 3, 2008, would be 11/03/08).

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8 a-b — Patient Name

Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin's Enrollment Verification System (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.

Form Locator 9 a-e — Patient Address

Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "On file"). If computer software does not automatically complete this element, enter information such as the member's complete address in field 9a.

Form Locator 10 — Birthdate

Enter the member's birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex (not required)

Form Locator 12 — Admission Date (not required)

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src (not required)

Form Locator 16 — DHR (not required)

Form Locator 17 — Stat (not required)

Form Locators 18-28 — Condition Codes (required, if applicable)

Enter the code(s) identifying a condition related to this claim, if appropriate. Refer to the UB-04 Billing Manual for more information.

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locators 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount
Enter the applicable value code and associated amount. Enter covered days using value code "80" and enter the number of covered days in the corresponding amount field using two decimal places. (For example, to indicate one day, providers would enter "1.00"; to indicate 12 days, providers would enter "12.00.") Enter noncovered days using value code "81" and enter the number of noncovered days in the amount field using two decimal places. Covered days must represent the actual number of visits (days of service) in the "From-Through" period in Form Locator 6.

Form Locator 42 — Rev. Cd.
Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rate/HIPPS Code
Enter the appropriate Healthcare Common Procedure Coding System code that corresponds to the revenue code listed in Form Locator 42.

Form Locator 45 — Serv. Date
Enter the single "from" date of service (DOS) in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units
Enter the number of covered accommodation days or ancillary units of service for each line item.

Units are measured in days for revenue codes "0169," "0651," "0655," and "0656" and in hours for revenue code "0652."

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)
Enter the usual and customary charges for each line item.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field
Enter the "to" DOS in DD format. A range of consecutive dates may be indicated only if the revenue code, the procedure code (and modifiers, if applicable), the service units, and the charge were identical for each date within the range.

Detail Line 23

PAGE ___ OF ___
Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS
Enter the sum of all charges for the claim in this field. 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*.

Form Locator 50 A-C — Payer Name
Enter all health insurance payers here. Enter "T19" for Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the *first page* of the claim.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel. Info (not required)

Form Locator 53 A-C — Asg. Ben. (not required)

Form Locator 54 A-C — Prior Payments (required, if applicable)
Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

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

Form Locator 55 A-C — Est. Amount Due (not required)

Form Locator 56 — NPI
Enter the provider's NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured's Name
Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured's Unique 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.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — Dx (not required)

Form Locator 67 — Prin. Diag. Cd.

Enter the valid, most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" (etiology) codes.

Form Locators 67A-Q — Other Diag. Codes

Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx (not required)

Form Locator 70 — Patient Reason Dx (not required)

Form Locator 71 — PPS Code (not required)

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74 a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending

Enter the attending provider's NPI.

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other (not required)

Form Locator 80 — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information

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

When the member has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 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 submit claims to ForwardHealth for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code 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 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 the provider is not Medicare certified.
  Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.
- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

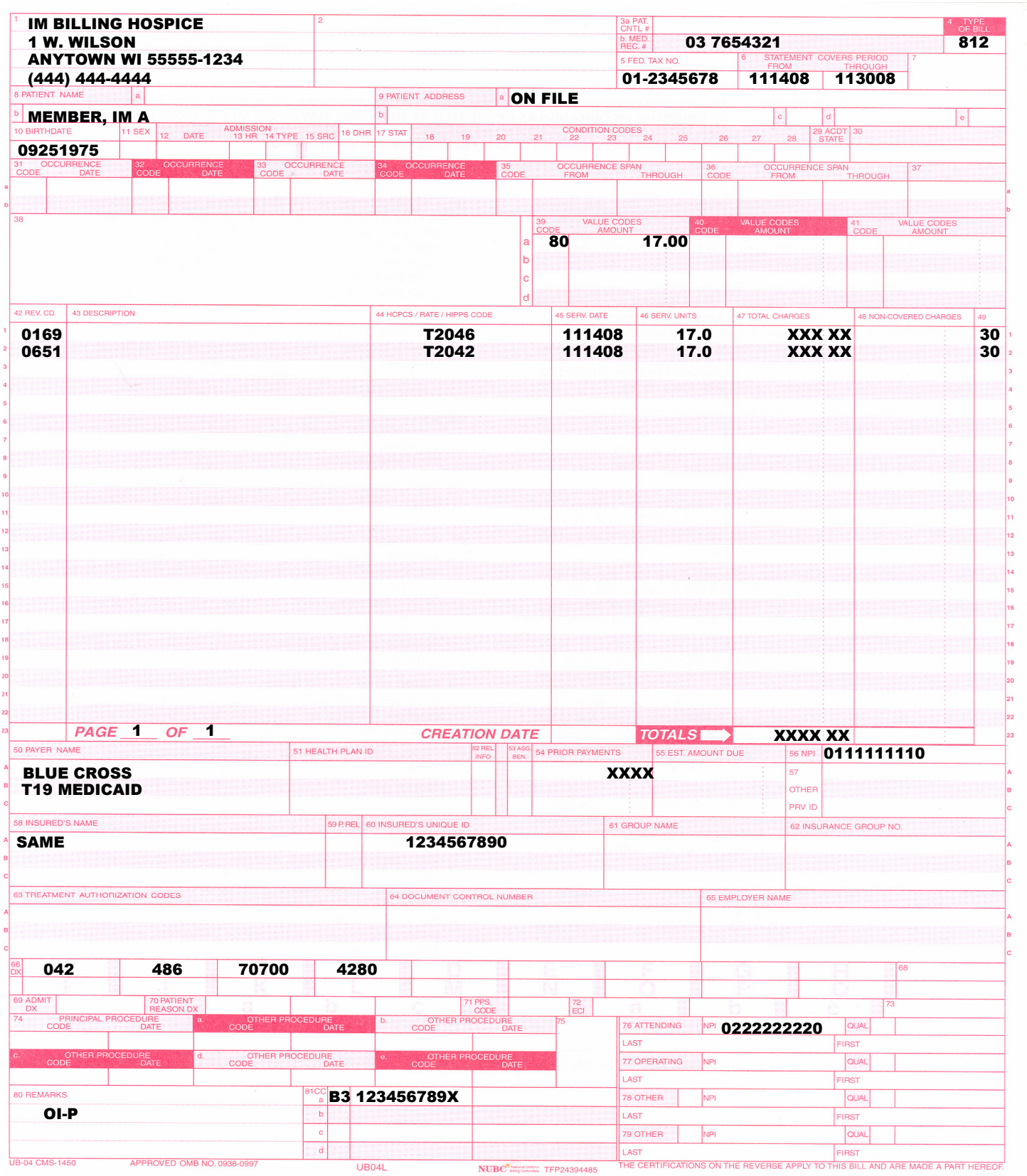
If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

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. Use M-7 in the following instances. *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 the service is not payable due to benefits being exhausted. *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 the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances. *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).

Form Locator 81 a-d — CC

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the 10-digit provider taxonomy code in the second field.

ATTACHMENT 2
Sample UB-04 Claim Form for Hospice Services



1 IM BILLING HOSPICE
1 W. WILSON
ANYTOWN WI 55555-1234
(444) 444-4444

3a PAT. CNTL #
b. MED. REC. # 03 7654321
4 TYPE OF BILL 812
5 FED. TAX NO. 01-2345678
6 STATEMENT COVERS PERIOD FROM 111408 THROUGH 113008

8 PATIENT NAME: MEMBER, IM A
9 PATIENT ADDRESS: ON FILE
10 BIRTHDATE: 09251975

39 VALUE CODES AMOUNT: 80 17.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0169		T2046	111408	17.0	XXX XX		30
0651		T2042	111408	17.0	XXX XX		30

PAGE 1 OF 1 CREATION DATE TOTALS XXXX XX

50 PAYER NAME: BLUE CROSS / T19 MEDICAID
54 PRIOR PAYMENTS: XXXX
56 NPI: 0111111110

58 INSURED'S NAME: SAME
60 INSURED'S UNIQUE ID: 1234567890

66 DX: 042 | 486 | 70700 | 4280

76 ATTENDING NPI: 0222222220

80 REMARKS: OI-P
81CC a: B3 123456789X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04L NUBC TFP24394485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ATTACHMENT 3
Adjustment/Reconsideration Request Completion Instructions

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

(This page was intentionally left blank.)

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 enrollment status, accurate name, address, and member identification 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.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13046 (10/08)

STATE OF WISCONSIN

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

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.

ATTACHMENT 5
HCPCS Codes for Hospice Claim Forms

Providers will now be required to include a corresponding Healthcare Common Procedure Coding System (HCPCS) procedure code with each hospice revenue code submitted on the UB-04 Claim Form. The following table lists hospice revenue codes and the appropriate corresponding HCPCS code.

Hospice Revenue Code	Description of Revenue Code	Corresponding Hospice HCPCS Code	Description of HCPCS Code
0651	Hospice services – Routine home care (up to 7.5 hours/day)	T2042	Hospice routine home care; per diem
0652	Hospice services – Continuous home care (8-24 hours/day)	T2043	Hospice continuous home care; per hour
0655	Hospice services – Inpatient respite care	T2044	Hospice inpatient respite care; per diem
0656	Hospice services – General inpatient care	T2045	Hospice general inpatient care; per diem
0169	Room and board – Other (for skilled nursing facility)	T2046	Hospice long term care, room and board only; per diem