ForwardHealth
Wisconsin serving you

Update
July 2008

No. 2008-127

Affected Programs: Wisconsin Chronic Disease Program
To: All Providers

Wisconsin Chronic Disease Program Coordination of Benefits

This *ForwardHealth Update* describes coordination of benefits for Wisconsin Chronic Disease Program.

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 and adjustments 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.

This *Update* contains information applicable to providers of Wisconsin Chronic Disease Program (WCDP) chronic renal disease, adult cystic fibrosis, and hemophilia home care services. Providers should refer to future service-specific WCDP *Updates* for more information, including claim submission information.

This *Update* provides detailed information about WCDP coordination of benefits to assist providers in their understanding of how to submit claims to WCDP to receive reimbursement in a timely manner.

Coordination of Benefits

Payer of Last Resort

Wisconsin Chronic Disease Program is payer of last resort of any WCDP-covered services. When coverage exists, a provider is required to submit a claim to commercial health insurance sources, Medicare, Health Insurance Risk Sharing Program (HIRSP), Wisconsin Medicaid, BadgerCare Plus, and SeniorCare before submitting it to WCDP.

Wisconsin Chronic Disease Program chronic renal disease members are required to enroll in Medicare Part D, SeniorCare, or a commercial health insurance source for creditable drug coverage. Providers are required to submit claims to the member's other creditable coverage before claims are submitted to WCDP. Creditable drug coverage is drug coverage that is at least as good as standard Medicare Part D drug coverage.

A claim will be denied if it is not submitted to other payers or if other insurance explanation code or Medicare disclaimer code is used inappropriately. For example, if a member does not have Medicare, a Medicare disclaimer code should not be indicated on a

claim. Future service-specific *Updates* will include more information about other insurance explanation codes and Medicare disclaimer codes.

Wisconsin Chronic Disease Program will not reimburse the provider for performing a service if the provider receives payment for the service from workers' compensation or from civil liabilities (e.g., for injuries from an automobile accident).

Commercial Health Insurance

Providers are required to make a reasonable effort to exhaust all existing commercial health insurance sources before submitting claims to WCDP when the services provided are a covered benefit of the commercial health insurance source. The provider must not submit claims to WCDP and the commercial health insurance sources simultaneously. If a member is covered by commercial health insurance, WCDP only pays that part of costs remaining after the commercial health insurance sources have been exhausted up to the WCDP maximum allowable rate for medical services or the WCDP-allowed amount for drugs.

Wisconsin Chronic Disease Program defines commercial health insurance as any type of health benefit not obtained from Medicare, HIRSP, Wisconsin Medicaid, BadgerCare Plus, or SeniorCare. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan.

Insurance Disclosure Program

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

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

Reporting Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies. Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report form, F-1159 (10/08). Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by Wisconsin's Enrollment Verification System (EVS).
- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (e.g., the member does not live in the plan's service area).

Refer to the Attachment of this *Update* for a copy of the Other Coverage Discrepancy Report.

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report, ForwardHealth confirms the information and updates ForwardHealth member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information

submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- The provider verifies through the EVS that the member's other coverage information has been updated.
- The provider receives a written explanation from ForwardHealth.

Medicare

If a member is enrolled in Medicare, providers are required to submit claims to Medicare for Medicare-covered services. Submit Medicare claims first, as appropriate, to the following:

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

A Medicare crossover claim is a Medicare-allowed claim sent to WCDP for payment of coinsurance, copayment, and deductible for a member enrolled in Medicare and WCDP. There are two types of crossover claims based on who submits them to WCDP:

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

Automatic Crossover Claims

Effective with the implementation of interChange, claims submitted to Medicare will automatically cross over to WCDP if WCDP is the only other payer known to Medicare. An automatic crossover claim is a claim that Medicare automatically forwards to WCDP. Claims will be forwarded to WCDP if the following occur:

- The Medicare carrier has a crossover agreement with ForwardHealth.
- Medicare has identified that the services were provided to a member enrolled only in Medicare and WCDP.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan or other commercial health insurance source.

Note: Since WCDP is the payer of last resort, if Medicare is aware of other coverage besides WCDP, Medicare may automatically forward the claim to the other payer.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is any Medicare-allowed claim the provider submits to WCDP. Providers should submit a crossover claim in the following situations:

- The claim is for a member who is enrolled in a Medicare Advantage Plan.
- The automatic crossover claim was not processed by WCDP within 30 days of the Medicare processing date.
- Wisconsin Chronic Disease Program denied the automatic crossover claim, but may allow payment if additional information is supplied.
- The claim is for a member who is enrolled in Medicare and who has commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not enrolled in WCDP at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled in WCDP.

Wisconsin Medicaid and BadgerCare Plus

Wisconsin Medicaid and BadgerCare Plus do *not* automatically forward claims to WCDP when the member is enrolled in Wisconsin Medicaid or BadgerCare Plus and WCDP.

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
Other Coverage Discrepancy Report

(A copy of the "Other Coverage Discrepancy Report" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Health Care Access and Accountability
F-1159 (10/08)

FORWARDHEALTH
OTHER COVERAGE DISCREPANCY REPORT

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

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).

Personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

The use of this form is mandatory when notifying ForwardHealth of other health care coverage discrepancies. Attach additional pages if more space is needed.

Instructions: Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.

SECTION I — PROVIDER AND MEMBER INFORMATION

Name — Provider	Provider ID	
Name — Member (Last, First, Middle Initial)	Date of Birth — Member	Member Identification Number

SECTION II — MEDICARE PART A AND B COVERAGE

Member Medicare / HIC Number

❑ Add		❑ Remove	
❑ Part A Coverage	Start Date	❑ Part A Coverage	End Date
❑ Part B Coverage	Start Date	❑ Part B Coverage	End Date

SECTION III — COMMERCIAL HEALTH INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

❑ Add	❑ HMO	❑ Medicare Managed Care
❑ Remove	❑ Medicare Supplement	❑ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, ZIP Code)

Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date

Member Left HMO Service Area ❑ Yes ❑ No	Date Member Left HMO Service Area (If Applicable)

SECTION IV — REPORT INFORMATION

Name — Individual Completing This Report	Date Signed	Telephone Number / Extension
Name — Source of Information Included on This Report		Telephone Number / Extension

Mail to	Fax to	Comments
ForwardHealth Coordination of Benefits PO Box 6220 Madison WI 53716-6220	Coordination of Benefits (608) 221-4567	(Attach additional pages if necessary.)