

Affected Programs: Wisconsin Chronic Disease Program
To: End-Stage Renal Disease Service Providers

ForwardHealth Announces Changes to Paper and Electronic Claims Submission for Wisconsin Chronic Disease Program End-Stage Renal Disease Services

This *ForwardHealth Update* announces changes to paper and electronic claim submission for Wisconsin Chronic Disease Program (WCDP) providers of end-stage renal disease (ESRD) services, effective October 2008, with the implementation of the ForwardHealth interChange system and the adoption of National Provider Identifiers.

This *Update* includes an Adjustment/Reconsideration Request, F-13046 (10/08), with completion instructions.

Providers are required to follow Medicare's claim submission instructions for *all* ESRD services claims, whether they are Medicaid-only or crossover claims.

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 WCDP 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.

Wisconsin Chronic Disease Program (WCDP) providers are reminded that WCDP covers services directly related to chronic renal disease, adult cystic fibrosis, and hemophilia home care.

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. This is a new claim submission option with the implementation of ForwardHealth interChange.
- Paper, using the UB-04 Claim Form.

The PES software accommodates changes that result from the implementation of ForwardHealth interChange and National Provider Identifiers (NPIs). Provider Electronic Solutions software is available to providers and electronic billing services at no cost. Using PES software, providers may submit HIPAA-compliant electronic claims and adjustments to ForwardHealth. The PES software cannot be used to submit claims to Medicare or commercial health insurance payers.

Wisconsin Chronic Disease Program providers should refer to the ForwardHealth companion documents for more information about electronic transactions. Wisconsin Chronic Disease Program will no longer issue separate companion documents. Companion documents provide software firms, billing services and clearinghouses, and computer processing staff (known as trading partners) who manage the technical component (e.g., telecommunication, exchange file creation, translation) of electronic transactions with useful technical information about ForwardHealth's standards for HIPAA-compliant transactions. Companion documents include information to help trading partners successfully exchange HIPAA-compliant electronic transactions with ForwardHealth.

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 WCDP 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-6 Medicare Disclaimer Code

Medicare disclaimer code "M-6" (Recipient not Medicare eligible), previously disclaimer code "6" for WCDP providers, 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). Wisconsin Chronic Disease Program providers should note that if the "M-6" disclaimer code is indicated on the claim, the claim will be denied.

Elimination of Series Billing

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

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.

Valid National Drug Codes, Revenue Codes, Procedure Codes, and Modifiers

Valid National Drug Codes (NDCs), revenue codes, procedure codes, and modifiers from national code sets must be indicated on claims. Claims submitted with invalid codes will be denied.

UB-04 Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the UB-04 Claim Form. Claims received on the UB-92 Claim Form after implementation will be returned to the provider unprocessed.

Providers are required to follow Medicare's claim submission instructions for *all* end-stage renal disease (ESRD) services claims, whether they are WCDP-only or crossover claims.

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 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 Form Locator 43 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.

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.

Entering Dates on UB-04 Claims

Providers should enter the "from" date of service (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.

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.

Medicare Crossover Claims

Signature and Date Required

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.

Submission

Providers are required to submit an Explanation of Medicare Benefits (EOMB) to WCDP with Medicare crossover claims. An EOMB should not be submitted with a claim that has not crossed over to Medicare.

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 1 and 2 of this *Update* for the Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

Reimbursement

Wisconsin Chronic Disease Program has established maximum allowable fees for ESRD services based on Medicare rates.

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 DHFS.

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

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ATTACHMENT 1

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 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 2
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 |
|-----------------------|----|--------|-----------------------------------|-------------------|-------|-------|-------|-------------------|-------------------|-------------------------------|---------|-------------------------------|
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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.

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| 17. SIGNATURE — Billing Provider | 18. Date Signed |
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|---|-----------------------|-----------------------|------|------------------------|-------------|-------------|----------------|-----------------------|-----------------------|-----------------------|--|--|--|
| Mail completed form to the applicable address: <table style="width:100%; border: none;"> <tr> <td style="width:33%;">BadgerCare Plus</td> <td style="width:33%;">WCDP</td> <td style="width:33%;">WWWP</td> </tr> <tr> <td>Claims and Adjustments</td> <td>PO Box 6410</td> <td>PO Box 6645</td> </tr> <tr> <td>6406 Bridge Rd</td> <td>Madison WI 53716-0410</td> <td>Madison WI 53716-0645</td> </tr> <tr> <td>Madison WI 53784-0002</td> <td></td> <td></td> </tr> </table> | 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Maintain a copy of this form for your records. |
| 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 | | | | | | | | | | | | | |

