

Affected Programs: BadgerCare Plus, Medicaid

To: End-Stage Renal Disease Service Providers, HMOs and Other Managed Care Programs

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

This *ForwardHealth Update* announces changes to paper and electronic claim submission for 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 a revised 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 BadgerCare Plus and Wisconsin Medicaid members.

Implementation of ForwardHealth interChange

In October 2008, the Department of Health and Family Services (DHFS) 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.

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.

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) service claims, whether they are Medicaid-only or crossover claims.

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” 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.

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 and 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 revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

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 and Family Services (DHFS). 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 dhfs.wisconsin.gov/forwardhealth/.

PHC 1250

ATTACHMENT 1

Adjustment/Reconsideration Request Completion Instructions

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

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 pages.)

**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: <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													

