ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Federally Qualified Health Centers, Individual Medical Supply Providers, Medical Equipment Vendors, Pharmacies, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

ForwardHealth Encourages Providers to Include Specific Explanation of Medicare Benefits Information with Medicare Advantage Crossover Claims for Diabetic Supplies

Providers who submit Medicare Advantage crossover claims for diabetic supplies for members dually enrolled in a Medicare Advantage Plan and Wisconsin Medicaid or BadgerCare Plus are encouraged to include specific Explanation of Medicare Benefits information with the claim.

Providers Encouraged to Include Specific Explanation of Medicare Benefits Information on Claims

Providers who submit Medicare Advantage crossover claims for diabetic supplies for members dually enrolled in a Medicare Advantage Plan and Wisconsin Medicaid or BadgerCare Plus are encouraged to include specific Explanation of Medicare Benefits (EOMB) information with the claim. Submission of this information will promote timely claim processing.

ForwardHealth has created an optional form that providers may use to communicate EOMB information. Providers may develop their own form as long as it contains all the necessary information for claims processing. Refer to Attachments 1 and 2 of this *ForwardHealth Update* for the Explanation of Medicare Benefits for Diabetic Supply Claims form, F-00898 (10/13), and completion instructions. A copy of the form and instructions can be found on the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Providers may use any format to submit EOMB information, as long as all of the following information is included:

- An indication that the claim is for coordination of benefits (COB) with a Medicare Part B plan. If the primary payer is not indicated as Medicare Part B, the claim will process as Medicare Part D. ForwardHealth does not coordinate benefits for diabetic supplies with Part D as it is not a secondary payer for Part D.

  Note: As a reminder, providers are responsible for COBs. ForwardHealth is the payer of last resort. For more information about COBs, refer to the Coordination of Benefits section of the Pharmacy service area of the Online Handbook.

- The Medicare remittance paid date.
- The rendering provider's National Provider Identifier.
- The requested first date of service for the drug.
- The number of services such as units or, when applicable, days.

- The National Drug Code for each drug or Healthcare Common Procedure Coding System procedure code that is indicated on the claim.
- The modifier(s) that corresponds with each procedure code, if applicable.
- The detail billed amount. At least one detail billed amount on the EOMB must match at least one detail amount on the claim.
- The Medicare allowed amount.
- The Medicare Deductible amount, if applicable.
- The Medicare Coinsurance amount, if applicable.
- The Group/Reason Code Amount such as the sum of the noncovered amounts, if applicable.
- The Medicare paid amount.
- The member's last name, first name, and middle initial.
- The Health Insurance Claim number.
- The member payment responsibility amount.
- The total billed amount on the Medicare claims. If the total billed amount on the EOMB does not match the total billed amount on the Medicare Claim, then at least one detail billed amount on the EOMB must match at least one detail billed amount on the fee-for-service claim.
- The Medicare adjusted amount(s).
- The Medicare interest amount, if applicable.
- The Medicare late filing charge, if applicable.
- The net total payment such as the provider paid amount or the amount after coinsurance and deductible.

If information on an EOMB attachment is incomplete, or if a claim for diabetic supplies for a dually enrolled member does not include an EOMB attachment, the claim will be returned to the provider.

Submitting Explanation of Medicare Benefits Information

ForwardHealth encourages providers to submit EOMB information as an attachment. Providers may develop their own form when submitting EOMB information.

When submitting electronic Medicare Advantage crossover claims, providers cannot submit a paper EOMB as an attachment. Providers are required to complete Medicare claim adjustment segments to provide EOMB information. Refer to the Provider-Submitted Crossover Claims topic (topic #4957) in the Medicare chapter of the Coordination of Benefits section of the ForwardHealth Online Handbook for more information.

When submitting paper Medicare Advantage crossover claims, providers are required to submit EOMB information on paper and attach it to the paper 1500 Health Insurance Claim Form.

Providers cannot submit EOMB attachments through the Portal or Provider Electronic Solutions.

Note: Providers only billing Medicare Part B may also utilize the Explanation of Medicare Benefits for Diabetic Supply Claims form.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership are provided by the member's managed care organization.

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). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

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

P-1250

ATTACHMENT 1
Explanation of Medicare Benefits for Diabetic Supply Claims Completion Instructions

(A copy of the "Explanation of Medicare Benefits for Diabetic Supply Claims Completion Instructions" is located on the following pages.)

FORWARDHEALTH
EXPLANATION OF MEDICARE BENEFITS FOR DIABETIC SUPPLY CLAIMS COMPLETION INSTRUCTIONS

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

Members of ForwardHealth 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 (DHS 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.

INSTRUCTIONS

The Explanation of Medicare Benefits for Diabetic Supply Claims form, F-00898, is to be completed by a provider and attached to a paper 1500 Health Insurance Claim Form. The Explanation of Medicare Benefits for Diabetic Supply Claims form is voluntary, and providers may develop their own form when submitting Explanation of Medicare Benefits information as long as it supplies all the necessary information for claims processing.

Completed forms should be submitted as attachments on paper. Providers are required to send paper attachments to the following address:

ForwardHealth
Ste 20
313 Blettner Blvd
Madison WI 53784

SECTION I — BILLING PROVIDER INFORMATION

Name — Billing Provider
Enter the billing provider's name.

Address — Billing Provider
Enter the address (street, city, state, and ZIP+4 code) of the billing provider.

SECTION II — EXPLANATION OF MEDICARE BENEFITS INFORMATION

Element 1 — Date Paid
Enter the Medicare remittance paid date in MM/DD/CCYY format.

Element 2 — National Provider Identifier — Rendering Provider
Enter the rendering provider's National Provider Identifier (NPI). This rendering provider's NPI must match the rendering provider's NPI indicated on the claim.

Element 3 — Date of Service
Enter the requested first date of service for the drug in MM/DD/CCYY format.

Element 4 — Number of Service
Enter the number of services such as units or days.

Element 5 — National Drug Code or Procedure Code
Enter the appropriate 11-digit National Drug Code for each drug or Healthcare Common Procedure Coding System procedure code that is indicated on the claim.

Element 6 — Modifier
Enter the modifier(s) that corresponds with each procedure code, if applicable.

Element 7 — Billed Amount
Enter the detail billed amount. At least one detail billed amount on the Explanation of Medicare Benefits (EOMB) must match at least one detail amount on the claim.

Element 8 — Allowed Amount
Enter the Medicare allowed amount.

Element 9 — Deductible
Enter the Medicare deductible amount, if applicable.

Element 10 — Coinsurance
Enter the Medicare coinsurance amount, if applicable.

Element 11 — Group/Reason Code Amount
Enter the sum of the noncovered amounts, if applicable.

Element 12 — Medicare Paid Amount
Enter the Medicare paid amount.

Element 13 — Name — Member
Enter the member's last name, first name, and middle initial.

Element 14 — Health Insurance Claim Number
Enter the Health Insurance Claim number.

Element 15 — Payment Responsibility — Member
Enter the member's payment responsibility amount.

Element 16 — Claim Total
Enter the total billed amount on the Medicare claims. If the total billed amount on the EOMB does not match the total billed amount on the Medicare claim, then at least one detail billed amount on the EOMB must match at least one detail billed amount on the fee-for-service claim.

Element 17 — Adjustment to Totals
Enter the Medicare adjusted amount(s).

Element 18 — Interest
Enter the Medicare interest amount, if applicable.

Element 19 — Late Filing Charge
Enter the Medicare late filing charge, if applicable.

Element 20 — Net Total
Enter the net total payment such as the provider paid amount or the amount after coinsurance and deductible.

Element 21
Indicate whether or not the claim is for Coordination of Benefits with Medicare Part B.

ATTACHMENT 2
Explanation of Medicare Benefits for Diabetic Supply Claims

(A copy of the "Explanation of Medicare Benefits for Diabetic Supply Claims" form is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00898 (10/13)

STATE OF WISCONSIN

FORWARDHEALTH

EXPLANATION OF MEDICARE BENEFITS FOR DIABETIC SUPPLY CLAIMS

Instructions: Type or print clearly. The information requested on this form is required for claims processing: however, the use of this form is voluntary, and providers may develop their own form when submitting Explanation of Medicare Benefits information. Providers are encouraged to include the informational elements below for members dually enrolled in a Medicare Advantage Plan and Wisconsin Medicaid or BadgerCare Plus.

SECTION I — BILLING PROVIDER INFORMATION

Name — Billing Provider

Address — Billing Provider (Street, City, State, ZIP+4 Code)

SECTION II — EXPLANATION OF MEDICARE BENEFITS INFORMATION

1. Date Paid					2. National Provider Identifier — Rendering Provider				
3. Date of Service	4. Number of Service	5. National Drug Code or Procedure Code	6. Modifier	7. Billed Amount	8. Allowed Amount	9. Deductible	10. Coinsurance	11. Group / Reason Code Amount	12. Medicare Paid Amount

13. Name — Member (First Name, Middle Initial, Last Name)	14. Health Insurance Claim Number	15. Payment Responsibility — Member

16. Claim Total

17. Adjustment to Totals	18. Interest
19. Late Filing Charge	20. Net Total

21. Is this claim for Coordination of Benefits with Medicare Part B? ❑ Yes ❑ No