ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin Chronic Disease Program, Wisconsin Well Woman Program
To: All Providers, HMOs and Other Managed Care Programs

ForwardHealth Is Postponing the Explanation of Medical Benefits Form Requirement for Paper Claims and Paper Claim Adjustments with Other Health Insurance Indicated

Effective December 10, 2014, ForwardHealth is postponing the requirement regarding submission of the Explanation of Medical Benefits form, F-01234 (11/14), with professional and institutional paper claims and paper claim adjustments with other health insurance indicated. Until further notice, providers should no longer submit Explanation of Medical Benefits forms with 1500 Health Insurance Claim Forms or UB-04 Claim Forms. This *ForwardHealth Update* includes revised completion instructions to indicate other insurance information (e.g., commercial insurance, Medicare) for the 1500 Health Insurance Claim Form, version February 2012 (02/12), in lieu of using the Explanation of Medical Benefits form. Other health insurance information should be indicated on the UB-04 claim form as it was prior to the introduction of the Explanation of Medical Benefits form.

Effective December 10, 2014, ForwardHealth is postponing the requirement regarding submission of the Explanation of Medical Benefits form, F-01234 (11/14), with paper claims and paper claim adjustments with other health insurance indicated. Until further notice, providers should no longer submit Explanation of Medical Benefits forms with 1500 Health Insurance Claim Forms or UB-04 Claim Forms. Explanation of Medical Benefits forms that were mailed with paper claims or paper claim adjustments prior to this announcement will be processed.

Information in this *ForwardHealth Update* supersedes information regarding the Explanation of Medical Benefits form that was published in the October 2014 *Updates* (2014-61 and 2014-62), titled "New Requirements for Paper Claims and Paper Claim Adjustments with Other Health Insurance Indicated" and "Changes to the 1500 Health Insurance Claim Form and Completion Instructions," respectively.

As a result of this postponement, the Explanation of Medical Benefits form and the Explanation of Medical Benefits form completion instructions, F-01234A (11/14), will be removed from the Forms page of the ForwardHealth Portal.

Dental claims, compound drug claims, noncompound drug claims, and their claim adjustments are not subject to the Explanation of Medical Benefits form requirement and, therefore, are not impacted by this postponement announcement.

Indicating Other Health Insurance Information on Paper Claims and Paper Claim Adjustments

1500 Health Insurance Claim Form Completion Instructions

The 1500 Health Insurance Claim Form (02/12) completion instructions published in *Update* 2014-62 have been revised to account for the postponement of the Explanation of Medical Benefits form requirement and to provide guidance on indicating other health insurance. Refer to the Attachment of this *Update* for a copy of the revised 1500 Health Insurance Claim Form completion instructions that will be incorporated into the Online Handbook.

As a reminder, effective November 12, 2014, ForwardHealth only accepts the 1500 Health Insurance Claim Form (02/12). Any previous versions of the 1500 Health Insurance Claim Forms received by ForwardHealth are returned to providers unprocessed.

UB-04 Claim Form Completion Instructions

Other health insurance information should continue to be indicated on the UB-04 claim form as it was prior to the introduction of the Explanation of Medical Benefits form. Providers should refer to the Submission chapter of the Claims section of the Online Handbook for the UB-04 Claim Form completion instructions specific to their service area.

Electronic Claim Submission Options

Providers are encouraged to submit claims electronically via the 837 Health Care Claim transactions, the ForwardHealth Portal, or Provider Electronic Solutions software. Refer to the Electronic Claim Submission topic (topic #344) in the Submission chapter of the Claims section of the Online Handbook for more information.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization (MCO). Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

Members who are enrolled in the Wisconsin Chronic Disease Program only are not enrolled in MCOs.

ATTACHMENT
1500 Health Insurance Claim Form (02/12) Completion Instructions

These instructions are for the completion of the 1500 Health Insurance Claim Form (02/12) for ForwardHealth. Refer to the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the National Uniform Claim Committee (NUCC) and available on their Web site, *www.nucc.org/*, to view instructions for all item numbers not listed below.

Use the following claim form completion instructions, in conjunction with the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC, to avoid denial or inaccurate claim payment. Be advised that every code used is required to be a valid code, even if it is entered in a non-required field. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations to covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans) must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial insurance billing as determined by ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Item Number 6 — Patient Relationship to Insured

Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 9 — Other Insured's Name

When applicable, commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Item Number 9 blank.

If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, one of the following three OI explanation codes must be indicated in the first box of Item Number 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. (Item Numbers 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Item Number 29 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 bill ForwardHealth for services that are included in the capitation payment.

Item Number 9a — Other Insured's Policy or Group Number

This field is not used for processing by ForwardHealth.

Item Number 9d — Insurance Plan Name or Program Name

This field is not used for processing by ForwardHealth.

Item Number 10d — Claim Codes (Designated by NUCC)

When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available at *www.nucc.org/* under Code Sets.

Item Number 11 — Insured's Policy Group or FECA Number

When applicable, if an Explanation of Medicare Benefits (EOMB) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

Use the first box of this item number only. (Item Numbers 11a, 11b, 11c, and 11d are not required.) Item Number 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, 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 that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the EOMB, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. 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. *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 enrolled in 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 exhausted benefits. *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 enrolled in 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 exhausted benefits.

Code	Description
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. *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 enrolled in 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 enrolled in 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).

Item Number 11d — Is There Another Health Benefit Plan?

This field is not used for processing by ForwardHealth.

Item Number 19 — Additional Claim Information (Designated by NUCC)

When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

If a provider bills an unlisted (or not otherwise classified) procedure code, a description of the procedure must be indicated in this field. If a more specific code is not available, the provider is required to submit the appropriate documentation, which could include a prior authorization request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

Item Number 22 — Resubmission Code and/or Original Reference Number

This field is not used for processing by ForwardHealth.

Section 24

The six service lines in section 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

For provider-administered drugs: National Drug Codes (NDCs) must be indicated in the shaded area of Item Numbers 24A-24G. Each NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier N4, followed by the 11-digit NDC, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12.

Item Number 24C — EMG

Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

Item Number 29 — Amount Paid

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

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

If a dollar amount indicated in Item Number 29 is greater than zero, "OI-P" must be indicated in Item Number 9. If the commercial health insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.