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ForwardHealth UPDATE

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NEW BENEFIT FOR RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT

For dates of service (DOS) on and after February 1, 2021, ForwardHealth will begin coverage of the new residential substance use disorder (SUD) treatment benefit for BadgerCare Plus and Medicaid members. This ForwardHealth Update offers policy information for covered and noncovered services, prior authorization (PA), claims submission, and reimbursement. Attachment A of this Update provides definitions of residential SUD treatment services. Attachment B of this Update clarifies enrollment information and residential SUD treatment provider specialty enrollment criteria. Enrollment for residential SUD treatment providers begins on December 14, 2020.

Overview

ForwardHealth created the new residential SUD treatment benefit in response to a Medicaid coverage gap that prevented member access to residential SUD treatment services and continuity of care.

AFFECTED PROGRAMS
BadgerCare Plus, Medicaid

TO
Residential Substance Use Disorder Treatment Providers, HMOs and Other Managed Care Programs

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WISCONSIN DEPARTMENT of HEALTH SERVICES

The 2015–2017 biennial budget authorized Wisconsin Medicaid to cover residential treatment through two program types delivered by facilities certified by the Division of Quality Assurance: those described in Wis. Admin. Code § DHS 75.11, medically monitored treatment; and Wis. Admin. Code § DHS 75.14, transitional treatment.

In May 2017, Wisconsin Medicaid implemented limited residential SUD treatment services under the Comprehensive Community Services (CCS) program. These services were subject to the institution for mental disease (IMD) exclusion, a provision of federal Medicaid law since the program's beginning in 1965. The IMD exclusion is a clause in the Medicaid program that prohibits federal funding for services provided in facilities with more than 16 beds for members aged 21–64. Because two-thirds of the Division of Quality Assurance-certified residential SUD treatment capacity in Wisconsin exists in IMDs, the CCS benefit has a limited ability to address the needs of Medicaid members.

The new residential SUD treatment benefit was developed under a Section 1115 demonstration waiver, which allows Wisconsin Medicaid to claim federal funding for residential SUD services provided in IMDs. All medically monitored treatment and transitional treatment facilities certified in Wisconsin under Wis. Admin. Code §§ DHS 75.11 and 75.14 will be eligible for reimbursement under the new residential SUD treatment benefit, regardless of IMD designation. The residential SUD treatment benefit does not include coverage in non-treatment residential settings, such as sober living homes, recovery residences, or community living arrangements.

> **"The residential SUD treatment benefit is available to members of all ages who are enrolled in a full-benefit Medicaid plan and who are pursuing recovery from one or more SUDs.**

Covered Services

The residential SUD treatment benefit is available to members of all ages who are enrolled in a full-benefit Medicaid plan and who are pursuing recovery from one or more SUDs.

Residential SUD treatment services must be provided in a facility with 24-hour supervision and be clinically and medically necessary. Residential SUD treatment will be provided at two levels of intensity by medically monitored treatment facilities (high intensity) and/or transitional treatment facilities (low intensity) certified by the Division of Quality Assurance.

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All of the following services are reimbursed as part of the residential SUD daily rate.

Assessment and Treatment Planning

This service component includes screening, intake, comprehensive assessment, diagnosis, and treatment planning. Providers must complete assessments using the American Society for Addiction Medicine (ASAM) placement criteria.

An assessment that establishes the member's ASAM level of care (LOC) must be completed by a qualified SUD clinician (see the Prior Authorization Requirements section of this Update) no more than 30 days prior to the member's admission to the residential treatment facility. The assessment must identify the member's unique medical conditions; mental health conditions; substance use history; current use, and related symptoms; wellness and nutritional needs; and social and spiritual needs. Throughout the member's residential treatment, ongoing re-assessment and treatment plan updates must be completed as required by Wis. Admin. Code ch. DHS 75.

Medical screenings shall be conducted by any of the following to identify health problems and screen for communicable diseases, as required by Wis. Admin. Code ch. DHS 75:

- Physician
- Physician assistant
- Nurse prescriber
- Registered nurse
- Licensed practical nurse

Per Wis. Admin. Code ch. DHS 75, medical screening is required unless the member's case record includes documentation of a recent medical screening prior to admission. Medical screenings conducted by the residential SUD treatment provider as part of the admission process are included in the daily rate.

Treatment Services

Treatment services may include the following:

- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Psychoeducation
- Medication management

RESOURCES

For the definitions of these treatment services, refer to Attachment A at the end of this Update.

- Nursing services
- Case management
- Peer support services
- Recovery coaching

To align with ASAM practice standards, high-intensity treatment requires 20 or more hours of treatment services per week for each member. Low-intensity treatment requires six or more hours of treatment services per week for each member.

Clinical services, which include the following, must be delivered by clinical staff within their scope of practice:

- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Psychoeducation
- Medication management
- Nursing services

For definitions of these clinical services, providers should refer to Attachment A of this Update. Clinical staff include the following:

- Psychologists
- Mental health professionals
- Mental health professionals in training
- Substance abuse counselors
- Substance abuse counselors in training
- Physicians
- Physician assistants
- Advance practice nurse prescribers
- Registered nurses and licensed practical nurses
- Other licensed professionals with specialized knowledge and training in mental health and SUDs

“ForwardHealth requires at least one hour of individual counseling with clinical staff per patient per week for both high-intensity and low-intensity services.

ForwardHealth requires at least one hour of individual counseling with clinical staff per patient per week for both high-intensity and low-intensity services.

Certified peer specialists have completed formal training for providing mental health or SUD supports, resulting in a certification recognized by Wisconsin Medicaid. Recovery coaches have completed formal, documented training in recovery services and systems, and approaches for promoting

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member engagement in treatment. These individuals help members engage in treatment services or recovery systems. No more than eight hours per week of peer and recovery coach services may count toward the required 20 hours of high-intensity services. No more than two hours per week of peer and recovery coach services may count toward the required six hours of low-intensity services.

Drug Testing

This service component includes drug testing to monitor and reinforce individual treatment gains. ForwardHealth will not separately reimburse residential SUD providers for urine dip screen drug testing or for specimen collection fees for samples sent for laboratory testing for any DOS with a residential SUD claim. Laboratories may be reimbursed for testing of specimens collected at the residential SUD facility for the types and frequency of testing described in current policy. Visit the Testing for Drugs of Abuse topic (#17959) in the Online Handbook for more information about drug testing limits. Drug testing provided as part of the narcotic treatment services benefit for members receiving medication-assisted treatment may be reimbursed under that benefit.

Related Services

The following services are often rendered concurrently by other provider types while a member is receiving residential SUD services. These related services are not included in the daily rate for this benefit. However, the following services may be reimbursed separately according to the coverage and reimbursement policies associated with each service, when they are determined to be medically necessary and non-duplicative, per Wis. Admin. Code § DHS 101.03(96m).

For the following related services, providers are subject to the policy requirements and limitations of the member's HMO or managed care organization (MCO), or as outlined in the ForwardHealth Online Handbook for members who are covered on a fee-for-service basis.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) must be available to members who require it. Residential SUD treatment providers must provide MAT medication on site or enable access to the medication off site, and may not deny services to someone receiving MAT. This includes all forms of MAT, which may be

RELATED SERVICES

The following are related services:

- MAT
- Psychiatric services
- Home health services
- Medical services
- Non-emergency medical transport

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provided via programs certified under Wis. Admin. Code ch. DHS 75.15 or by Medicaid-enrolled prescribers with experience and required waivers to provide MAT.

Medicaid-enrolled narcotic treatment service providers and MAT prescribers who provide assessment, drug testing, other disease screening, prescribing, and administration of narcotic medications may be reimbursed separately from the daily rate. Pharmacy costs are reimbursed through the pharmacy benefit. Counseling services rendered by narcotic treatment service providers, as required by federal and state rules, are reimbursed through the outpatient substance abuse benefit.

Psychiatric Services

Physicians and other qualified health professionals who perform psychiatric evaluation and management services, which may include psychotherapy performed with an evaluation and management service, may be reimbursed separately from the daily rate. Providers are reminded that medical screening upon admission, the initial biopsychosocial assessment, and supervision of staff by a psychiatrist are included in the daily rate and may not be billed separately. For fee-for-service members, psychiatric evaluation and management services must be submitted on a professional claim form and may not be billed on the institutional claim form for the residential SUD facility.

Health Home Services

For members concurrently enrolled in a Wisconsin Medicaid health home, all health home services, including care management and care coordination, may be provided and reimbursed while the member is engaged in residential SUD treatment.

Medical Services

The residential SUD treatment facility must facilitate access to needed medical care that is outside the scope of residential SUD treatment. Medical services rendered by providers not employed by the residential SUD facility, including medical consultation provided via telehealth, may be reimbursed separately from the daily rate.

Non-Emergency Medical Transportation

Members may use the non-emergency medical transportation benefit for transportation to the residential facility and for transportation to Medicaid-coverable medical appointments during residential treatment. Non-emergency

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medical transportation is not included as a part of the residential SUD treatment benefit but is available to Medicaid and BadgerCare Plus members to facilitate their treatment. Visit the Wisconsin Department of Health Services non-emergency medical transportation webpage for more information about this benefit. Non-emergency medical transportation is covered by the Family Care, Family Care Partnership, and Program of All Inclusive Care for the Elderly (PACE) programs for members enrolled in those programs.

Noncovered Services

ForwardHealth will not reimburse noncovered services. Examples of noncovered services include:

- Acute withdrawal management or detoxification concurrent with residential SUD treatment (ForwardHealth expects that any services for acute intoxication or withdrawal have already been provided before starting a residential treatment program. Refer to Wis. Admin. Code ch. DHS 75 for more information on withdrawal management or detoxification.)
- Day treatment and outpatient mental health services concurrent with residential SUD treatment
- Outpatient SUD services concurrent with residential SUD treatment, except for counseling services provided through the Narcotic Treatment Services benefit
- Services that are recreational, social, academic, vocational, or unrelated to the direct treatment of the SUD
- Services delivered outside the parameters of the PA
- Room and board expenses related to residential SUD treatment (Members may use other sources to pay for room and board.)

Some of these services may be covered by the Include, Respect, I Self-Direct (IRIS), Family Care, Family Care Partnership, and PACE programs for members participating in those programs.

Program Requirements

Residential SUD treatment providers must admit members who take medications for SUDs (for example, Food and Drug Administration-approved methadone, buprenorphine, and naltrexone) or mental health conditions. Following admission, with a signed release, the residential SUD treatment provider should collaborate with the prescriber regarding medications and

RESOURCES

For more information about noncovered services, refer to Wis. Admin. Code § DHS 101.03(103) and ch. DHS 107.

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the overall treatment plan. Residential SUD treatment providers must also be able to support the member continuing to use prescribed medication including their MAT medication, either by providing the medication on site or enabling access to the medication off site.

In addition, services provided must address the member's individual needs, as documented in the treatment plan. Services provided must also meet the definition of medical necessity as defined in the Medical Necessity topic (#84) of the Online Handbook.

Finally, a covered service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. The service must meet all applicable program requirements, such as those related to claims submission, PA, and Department of Health Services certification.

Prior Authorization

ForwardHealth has established clinical criteria for PA requests for residential SUD treatment effective for DOS on and after February 1, 2021.

All residential SUD treatment services require PA. Authorization requests for initial admission completed via the ForwardHealth Portal may result in an automatic approval for the first 10 days of treatment. This authorization may be extended up to 30 days by submitting an amendment request. Authorization requests for treatment beyond 30 days will be evaluated based on the medical necessity of the request.

NEW PA FORM

Prior Authorization/Residential Substance Use Disorder Treatment Attachment (PA/RSUD) form, F-02567 (01/2021)

Forms and Attachments

The PA request must be submitted by the enrolled residential SUD provider and must include the following, which can be found on the Forms page of the Portal:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/2013)
- A completed Prior Authorization/Residential Substance Use Disorder Treatment Attachment (PA/RSUD) form, F-02567 (01/2021), which includes diagnostic evaluation and ASAM criteria

Prior Authorization Requirements for Initial Requests for Residential Substance Use Disorder Treatment

An initial PA request is the first request to ForwardHealth for a member for an episode of residential SUD treatment. This may include instances when

the member's residential SUD treatment is already in progress but covered by a payer other than Wisconsin Medicaid. An initial PA request may also include requests for residential treatment at a different level of intensity. Initial requests submitted via the ForwardHealth Portal may result in automatic approval of the first 10 days of treatment.

The initial assessment of the member to determine the appropriateness of residential treatment admission must be completed by one of the following:

- Licensed clinical substance abuse counselor or substance abuse counselor
- Licensed marriage and family therapist, licensed professional counselor, or licensed clinical social worker
- Licensed marriage and family therapist in training, licensed professional counselor in training, or substance abuse counselor in training, with sign-off by clinical supervisor
- Certified addiction registered nurse
- Psychologist
- Physician familiar with ASAM placement criteria

Failing to perform or document the initial assessment of a member could lead to denial or recovery of claims or both. Refusal to produce documentation may result in sanctions including, but not limited to, termination from the Medicaid program.

Requests for initial admission for either high-intensity or low-intensity treatment may be automatically approved for up to 10 calendar days via the ForwardHealth Portal.

Diagnostic Evaluation

The diagnosing clinician must identify each of the member's current symptoms from the diagnostic criteria listed in the current Diagnostic and Statistical Manual for SUDs. To be eligible for residential treatment, the member must meet the diagnostic criteria for a moderate or severe SUD. The diagnosing clinician must specify the substances used by the member and the severity of symptoms associated with each substance.

American Society of Addiction Medicine Criteria

The residential SUD provider must submit a current assessment of the member's ASAM level of functioning and severity as described in the current edition of "The ASAM Criteria: Treatment Criteria for Addictive, Substance-

Related, and Co-Occurring Conditions." The assessment must include the following:

- A brief narrative description for each ASAM dimension
- The member's risk rating for each ASAM dimension to specify severity of needs and treatment priorities
- The member's LOC rating for each ASAM dimension to specify the least restrictive intensity of services needed to address each dimension

Documentation must clearly support the provider's determination of the member's LOC.

Requests Not Eligible for Automatic Approval

Not all PA requests are eligible for automatic approval. The following PA requests for initial admission will not be considered for automatic approval via the ForwardHealth Portal:

- PA requests that indicate a LOC other than residential SUD treatment
- PA requests submitted via mail or fax
- Amendments to extend an existing PA request
- PA requests that were not completed accurately

PA requests submitted through the Portal will be routed and processed by a behavioral health clinician if they are not eligible for automatic approval.

Prior Authorization Requirements for Requests to Extend Services up to 30 Days

Following admission to the treatment facility, providers may submit a PA amendment request to extend the member's medically necessary residential treatment up to 30 days from the date of initial admission. The amendment must be submitted before the expiration of the initial authorization. This request may be submitted immediately after receiving approval for the initial authorization. The PA amendment must include:

- A completed Prior Authorization Amendment Request form, F11042 (07/2012)
- Provider's comprehensive biopsychosocial assessment
- Plan of care
- Discharge criteria and continuing care plan

If the amendment request is submitted after the expiration of the current PA, a new PA request must be submitted for consideration. PA will not be backdated to cover the gap in services because of untimely submissions.

REMINDER

The member should utilize the least restrictive LOC that results in progress related to the treatment plan. If the member meets a less restrictive LOC than residential treatment, those services should be utilized first.

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Prior Authorization Amendment Request Form

The provider must complete all required fields on the Prior Authorization Amendment Request form, including the following:

- In Element 9, indicate the desired end date for the PA. This may be up to 30 calendar days from the date of admission.
- In Element 10, indicate "Change Grant or Expiration Date."
- In Element 11, include the note "Extend initial stay to (number up to 30 from admission date) days" with any other desired information.

Comprehensive Biopsychosocial Assessment

The provider must submit a comprehensive biopsychosocial assessment of the member following the requirements of the current version of ASAM including, but not limited to:

- History of the present episode
- Personal and social history (for example, school, work, military service, relationships)
- Family and developmental history
- Alcohol, tobacco, other drug use, and addictive behavior history
- Legal history
- Psychiatric history and mental health status examination
- Treatment history for substance abuse
- Medical history, formulation, diagnosis, survey of assets, vulnerabilities and supports, and treatment recommendations.

A recent biopsychosocial assessment may be used in lieu of completing a new assessment, provided the assessment is not more than 30 days old. The comprehensive biopsychosocial assessment may be conducted by a qualified clinician referring the member for residential SUD treatment.

If the biopsychosocial assessment results in changes to previously submitted information, such as diagnosis details, ASAM dimensions, or LOC, documentation must detail the updates and provide an explanation for the differences.

Plan of Care

The provider must submit a plan of care, also known as a treatment plan or protocol, which meets all requirements described in Wis. Admin. Code ch. DHS 75. The plan of care must address the member's priority needs, based on the ASAM assessment, and must identify the specific, measurable outcomes

used to evaluate progress and treatment success. The plan of care must also identify any diagnosed mental health conditions or psychiatric symptoms seen or reported by the member, and the plan for integrating and addressing these conditions in treatment.

If the member has medical needs or requires MAT, the plan of care must specify how these medical conditions will be addressed, including a plan for obtaining MAT, if needed.

Discharge and Continuing Care Plan

The provider must begin preparing a continuing care plan shortly after admission to identify the expected needs of the member and available resources in the community to address the member's needs related to ongoing recovery. The member and the member's family, when applicable, must be involved in the process and have a thorough understanding of the plan. The initial continuing care plan must include:

- Documented coordination with the member's care manager for the next LOC, which may include the member's HMO/managed care organization, psychosocial rehabilitation program, Medicaid health home, or other care manager
- Planning for services upon discharge, such as individual counseling, group counseling, medication management, attendance at recovery support group meetings, and interim support plans, as needed
- Confirmation of living arrangements that will encourage recovery and reduce the chances of relapse
- Emergency and counseling contact information for the member
- Overdose prevention plan, if applicable, including continuation of MAT and provision of emergency medication to treat overdoses

The provider may keep developing and modifying the initial continuing care plan during the rest of the member's treatment stay. However, all requests to extend the member's stay in residential treatment will require evidence of timely efforts to develop an effective continuing care plan (such as dates of member meetings and phone contacts, and documentation of care coordination with other care/case management entities). Care coordination must include helping the member actively pursue appropriate living arrangements to avoid continued treatment when the primary barrier to discharge is the need for an adequate recovery environment. Failure to develop an adequate plan for discharge may result in a denial of authorization for added days of service.

Prior Authorization Requirements for Requests to Extend Services Beyond 30 Days

A PA amendment may be submitted to request an extension of services under the initial PA number for continued stay at the ASAM-indicated residential LOC. The provider must submit the amendment request before the current PA expires to prevent a gap in services. If the amendment is not submitted before the current PA expires, a new PA request must be submitted. PAs will not be backdated to cover gaps of services because of untimely submissions.

Following the initial 30 days of residential treatment, requests for clinically managed high-intensity residential services may be extended for up to 10 days per amendment request. Exceptions may be granted for pregnant or postpartum members up to 60 days after the child's birth.

Following the initial 30 days of residential treatment, requests for clinically managed low-intensity residential services may be extended for up to 30 days per amendment request.

For requests to extend services at either LOC, the following information is required to make a determination of medical necessity for a PA amendment request:

- A completed Prior Authorization Amendment Request form
- All treatment plan reviews
- Updated ASAM criteria
- Updated plan of care
- Clinical rationale for continued stay
- Updated discharge and continuing care plan

Prior Authorization Amendment Request

The provider must complete all required fields on the Prior Authorization Amendment Request form, including the following:

- In Element 9, indicate the desired end date for the PA. For high-intensity treatment, this may be up to 10 days from the current expiration date. For low-intensity treatment, this may be up to 30 days from the current expiration date.
- In Element 10, indicate "Change Grant or Expiration Date."
- In Element 11, include the note "Additional 10 days requested" or "Additional 30 days requested" with any other desired information.

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Treatment Plan Reviews

Providers must submit all treatment plan reviews completed since the last PA request. Documentation must include the date of each review, the individual completing the review, and narrative descriptions of changes and progress toward goals.

Updated American Society of Addiction Medicine Criteria

Providers must submit an updated assessment of the member's level of functioning and severity using the ASAM criteria. Providers must also include brief narrative descriptions, risk ratings, and LOC ratings for each of the six ASAM dimensions.

Updated Plan of Care

Providers must submit an updated plan of care and identify any new or modified goals, progress made, and changes to the treatment protocol.

Clinical Rationale for Continued Stay

Providers must submit a clear clinical rationale for continued stay beyond the authorized expiration date. Providers must also identify barriers to discharge, all attempted corrective actions and timeline, the plan to resolve barriers, and the anticipated discharge or transfer date.

Updated Continuing Care Plan

Providers must submit the member's current continuing care plan that includes all the elements described in the Prior Authorization Requirements for Requests to Extend Services up to 30 Days section of this Update. Failure to develop a suitable plan of care for discharge may result in a denial of authorization for added days of service.

Changes in Member's Level of Care Needs

If the member's LOC changes during an authorization period, the provider must submit a PA amendment to end the current authorization. Providers are expected to submit a PA amendment within 48 hours of the member no longer meeting ASAM criteria for the authorized LOC. If the member requires a different level of residential SUD treatment, any provider certified to provide the needed LOC may submit an initial PA request for a new episode of residential SUD treatment at the new LOC. If the member requires a service other than residential SUD treatment, the provider should refer to the policy requirements and limitations of the member's HMO or as outlined in the

ForwardHealth Online Handbook for members whose medical services are covered on a fee-for-service basis.

Emergency Services

There are no PA requirements in emergency situations as defined by Wis. Admin. Code § DHS 101.03(52). Emergency services are **only** reimbursed if they are covered services. Providers may refer to the Emergency Services topic (#429) of the Online Handbook for more information.

Submission Options

Residential SUD treatment providers may submit PA requests for residential SUD treatment services using any of the following methods:

- **ForwardHealth Portal**—PA requests may be submitted on the Portal at www.forwardhealth.wi.gov/.
- **Fax**—PA requests may be faxed to 608-221-8616.
- **Mail**—PA requests may be mailed to the following address:
  ForwardHealth
  Prior Authorization
  Ste 88
  313 Blettner Blvd
  Madison WI 53784

For specific information about each of these submission options, providers should refer to the Submission Options chapter of the Online Handbook.

ForwardHealth encourages providers to use the Portal to reduce the chance of PA submission errors. If documentation related to the PA is being faxed or mailed to ForwardHealth, the provider is responsible for including the PA number and other member-identifying information so that the attachments are easily identified and assigned to the PA. Providers are reminded of their responsibility to submit complete and accurate PA requests. Incomplete submissions may result in delays to receiving a final decision on the request.

Authorization Dates

The requested start date for services on PA requests cannot be earlier than the date of the diagnostic evaluation and ASAM evaluation.

PA requests may not be backdated to a date earlier than the initial date of the PA request submission, except in limited circumstances.

Requests for backdating may be approved for up to 14 calendar days from the date of submission if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before the PA was granted, including the evaluation report.
- The request includes justification for why the PA could not be submitted immediately before or after the member was admitted.
- ForwardHealth receives the request within 14 calendar days of the start of the provision of services.

Prior Authorization Status Inquiries

Providers may ask about the status of a PA request through one of the following methods, using the 10-digit PA number received following submission of a PA request:

- Logging into the Portal and visiting the Prior Authorization page
- Accessing WiCall at 800-947-3544
- Calling Provider Services at 800-947-9627

Refer to the Decisions chapter of the Physician service area of the Online Handbook for more general information on PA status and decisions.

Reimbursement Not Available

ForwardHealth may decline to reimburse a provider for a service that has been prior authorized if one or more of the following applies:

- The service authorized on the approved PA request is not the service provided.
- The service is not provided within the grant and expiration dates on the approved PA request.
- The member is not eligible for the service on the date the service is provided.
- The provider is not enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is not billed according to service-specific claim instructions.
- The provider does not meet other program requirements.

Collecting Payment From Members

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider did not submit a PA request before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained an approved PA request but did not meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA request was denied.

For information about when providers may collect payments from members, refer to the Situations When Member Payment Is Allowed topic (#224) of the Online Handbook.

Refer to the Conditions That Must Be Met topic (#227) of the Online Handbook for more information on collecting member payments if a member requests a noncovered service, a covered service for which PA was denied (or modified), or a service not covered under the member's limited benefit category.

Claim Submission

ForwardHealth reimburses only for services that are medically necessary as defined under Wis. Admin. Code § DHS 101.03(96m). ForwardHealth may deny or recoup payment if a service does not meet Medicaid medical necessity requirements. Claims must be billed using the UB-04 (CMS 1450) Claim Form or the electronic 837 Health Care Claim: Institutional transaction for institutional claims and must include one revenue code and at least one procedure code.

Healthcare Common Procedure Coding System procedure codes and applicable modifiers are required on all claims. Claims or claim adjustments received without a valid Healthcare Common Procedure Coding System procedure code and corresponding modifier will be denied.

Procedure Codes and Modifiers

Effective for DOS on and after February 1, 2021, residential SUD treatment providers must include revenue code 1002 (Behavioral health accommodations residential-chemical dependency) on claims and claim

REMINDER

Information about submitting claims to ForwardHealth is found in the Online Handbook.

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adjustments with the procedure code H0018 (Behavioral health; short-term residential [non-hospital residential treatment program], without room and board, per diem).

PA is required for **all** claim submissions.

Claims or claim adjustments submitted to ForwardHealth for residential SUD treatment services must have a modifier to indicate the LOC (that is, the intensity of treatment) that was provided. Each line of detail on a claim or claim adjustment requires a modifier. The modifier included on the claim must match the modifier on the PA request. Claims and claim adjustments without the required modifier will be denied.

Providers should bill only one type of service, either clinically managed low-intensity residential services or clinically managed high-intensity residential services, per claim. Providers may include other revenue codes on the claim, but ForwardHealth will only reimburse the established daily rate.

Required modifiers for claims submission for procedure code H0018 are listed in the table below.

MODIFIER	DEFINITION	PROVIDER SPECIALTY
TG	Complex/high tech level of care	Only high-intensity provider specialties of the residential SUD treatment provider type will be able to use this modifier.
TF	Intermediate level of care	Only low-Intensity provider specialties of the residential SUD treatment provider type will be able to use this modifier.

Optional modifiers may be included on the claim to indicate clinical complexities associated with the member's treatment. These modifiers should be included on the claim after the intensity of treatment modifier (TG or TF). Allowable optional clinical complexity modifiers are listed in the table below.

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MODIFIER	DEFINITION	WHEN TO USE
HD	Pregnant/parenting women's program	The HD modifier may be used for members who are currently pregnant through 60 days post-partum.
HA	Child/adolescent program	The HA modifier may be used for members who are currently under the age of 18.
HI	Integrated mental health and intellectual disability/ developmental disabilities program	The HI modifier may be used when a member has a documented intellectual or developmental disability that requires the clinician to significantly adapt the treatment approach to accommodate the member's comprehension and communication limitations.

Providers must submit **all** applicable clinical complexity modifiers; however, only the clinical complexity modifier with the highest reimbursement rate will enhance the payment.

Coordination of Benefits

Commercial Health Insurance

When a member is enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid, the provider is required to submit claims to commercial health insurance sources before submitting claims to ForwardHealth. This is done by following the process in the Exhausting Commercial Health Insurance Sources topic (#596) of the Online Handbook.

Even when a member has a known deductible or cost share, primary insurance must process the claim before submission to ForwardHealth. The outcome of the primary insurance claim, regardless of payment status, is required for ForwardHealth to process secondary claims.

When coordinating commercial insurance and Medicaid benefits, providers are required to bill the commercial health insurance plan according to the commercial insurer's policies and designated procedure codes, modifiers, and units billed. After receiving the claims processing outcome (for example, Remittance Advice) from the commercial insurer, the provider may submit a

claim to ForwardHealth for consideration of any remaining balance, using the other insurance indicator or completing the Explanation of Medical Benefits form, F-01234 (04/2018), which providers can access through the Forms page of the Portal, as applicable.

ForwardHealth does not use billing crosswalks between commercial insurance procedure codes and ForwardHealth's allowable procedure codes in any benefit areas. Coordination of benefits claims are paid using the procedure code billed to the commercial insurance, up to ForwardHealth's allowable amount.

Note: The requirement for providers to submit claims to commercial insurance companies according to the commercial insurer's coding guidance does not waive other ForwardHealth program requirements. These requirements (for example, provider qualifications, medical necessity, and documentation requirements) are still in effect. ForwardHealth will not reimburse providers for services that do not meet program requirements.

Claims for Services Denied or Not Covered by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by BadgerCare Plus and Wisconsin Medicaid, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (for example, request PA before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Note: The provider is required to show that a correct and complete claim was denied by the commercial health insurance company for a reason other than that the provider was out of network.

ForwardHealth will not reimburse claims denied by commercial health insurance because of billing errors or when the provider was out of the commercial insurer's network of providers. ForwardHealth will only coordinate benefits when members use a provider in their commercial insurer's network.

ForwardHealth will consider reimbursement of claims denied by commercial health insurance when residential SUD treatment is not a covered benefit under the member's plan and/or when the member has reached their maximum annual benefit for residential SUD treatment.

QUICK LINKS

Forms page

REMINDER

Commercial health insurance benefit plans change on a regular basis. To follow Wisconsin state statutes, providers are required to confirm a member's coverage when the plan year changes and to update the member's file with any changes.

The information provided in this ForwardHealth Update is published in accordance with the policies included in the federally approved BadgerCare Reform 1115 Demonstration Waiver, per s. 20.940(3)(c)(2).

Discovery of Commercial Insurance After Payment by ForwardHealth

If, after paying a claim for residential SUD treatment, ForwardHealth discovers the member had commercial health insurance coverage on the DOS included on the claim, ForwardHealth will send an invoice to the provider for the paid claim. The provider is required to seek reimbursement from the commercial health insurer upon receipt of this invoice using the commercial insurer's policies and designated procedure codes, modifiers, and units billed. Refer to the Purpose of Provider-Based Billing topic (#660) of the Online Handbook for more information.

Medicare

State law limits reimbursement for coinsurance and copayment of Medicare Part B-covered services provided to dual-eligible members and Qualified Medicare Beneficiary-Only members.

Total payment for a Medicare Part B-covered service (that is, any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount; therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B-covered service is the lesser of the following:

- The Medicare-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member
- The Medicaid-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member

For more information on reimbursing crossover claims with Medicare, visit the Reimbursement for Crossover Claims topic (#686) in the Online Handbook.

Reimbursement

Residential SUD treatment benefit services are reimbursed fee-for-service for all BadgerCare Plus and Medicaid members.

Covered services will be reimbursed via a daily per diem rate. Daily per diem rates are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Refer to reimbursement rates available on the Portal for residential SUD treatment services.

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Member Information

Member Eligibility

The residential SUD treatment benefit is available to members of all ages. Members must be enrolled in a full-benefit BadgerCare Plus or Wisconsin Medicaid program to be eligible for the residential SUD treatment benefit. When receiving the residential SUD treatment benefit, members residing in an IMD are not subject to the eligibility restrictions that would normally apply to someone residing in an IMD.

A member residing in a facility for the sole purpose of SUD treatment is **not** considered to be residing in a medical institution, even if the benefit is delivered at a hospital or IMD. As a result, the member is not subject to patient liability requirements or other rules that normally apply to other members who reside for 30 days or more in a medical institution.

Providers may be required to submit documentation of residential SUD treatment enrollment in order for a member to establish or maintain their eligibility.

Retroactive Medicaid Enrollment

Retroactive enrollment occurs when an individual applies for BadgerCare Plus or Wisconsin Medicaid and enrollment is granted with an effective date before the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred before the date of application. The retroactive enrollment period may be backdated for up to three months before the month of application if all enrollment requirements were met during that period. Enrollment may be backdated more than three months if there were delays in determining enrollment. Enrollment may also be backdated if court orders, fair hearings, or appeals were involved.

Wis. Admin. Code § DHS 104.01(11) gives members who get retroactive enrollment the right to ask for the return of payments made to a Medicaid-enrolled provider for covered services during retroactive enrollment. A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during retroactive enrollment. Wisconsin Medicaid cannot directly refund the member.

If a service that requires PA was performed during the member's retroactive enrollment, the provider is required to submit a PA request as soon as the member's eligibility is granted and obtain approval from ForwardHealth **before** submitting the claim.

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If a provider receives reimbursement from Wisconsin Medicaid for a service provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member for the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS because of a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's Enrollment Verification System (if the services provided during retroactive enrollment were covered).

Member Enrollment Verification

Providers must verify a member's enrollment before submitting a PA request and before each DOS to which they are providing services. By verifying a member's enrollment, providers confirm enrollment for the current DOS (since a member's enrollment status may change). Daily verification of member enrollment also lets providers notice any limits to the member's coverage and reduces claim denials.

ForwardHealth will not authorize backdated services because of the provider's delay in checking eligibility.

Providers can access Wisconsin's Enrollment Verification System to get the most current enrollment information through the following methods:

- The ForwardHealth Portal
- WiCall, ForwardHealth automated voice response system, which gives responses to questions about claim status (800-947-3544)
- Commercial enrollment verification vendors
- The 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions
- Provider Services (800-947-9627)

Each enrollment verification method lets providers check the following:

- Member enrollment in a ForwardHealth program(s)
- State-contracted MCO enrollment
- Medicare enrollment
- Any other commercial health insurance coverage
- Exemption from copayments for BadgerCare Plus members

Note: The Enrollment Verification System does not indicate other government programs secondary to ForwardHealth. Providers cannot charge a member,

RESOURCES

- For more information about verifying member enrollment on the Portal, refer to the Enrollment Verification on the Portal (#4901) topic of the Online Handbook.
- For more information about the 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions, refer to the 270/271 Transactions (#256) topic of the Online Handbook.

The information provided in this ForwardHealth Update is published in accordance with the policies included in the federally approved BadgerCare Reform 1115 Demonstration Waiver, per s. 20.940(3)(c)(2).

or authorized person acting on behalf of the member, for verifying their enrollment.

Persons Detained by Legal Process

Individuals detained by legal process are not eligible for the residential SUD treatment benefit since they are not eligible for full Wisconsin Medicaid benefits. Providers can refer to the Persons Detained by Legal Process topic (#278) in the Online Handbook for more information.

Note: "Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners.

Copayments

Residential SUD treatment services are exempt from copayments. Providers are prohibited from collecting copayments from members for services covered under the residential SUD treatment benefit.

Members will be subject to premiums if such premiums are a condition of the member's eligibility. In addition, any member who is already enrolled in Wisconsin Medicaid as a resident of a nursing home or hospital, or as someone enrolled in Home and Community-Based Waivers, is still subject to patient liability and cost sharing rules, even if they are also receiving the residential SUD treatment benefit.

Comprehensive Community Services Coordination

There will be no changes to CCS coverage of residential SUD treatment services in non-IMD settings. CCS must cover treatment in non-IMD settings and will not be reimbursed for treatment delivered in an IMD.

If members enrolled in a CCS program are unable to access residential SUD treatment through their CCS program, they may access services through the residential SUD treatment benefit. Documentation substantiating the member's inability to access residential SUD treatment through their CCS program will be required with the PA request.

CCS services must be suspended during the member's residential SUD treatment; however, service planning and service facilitation may be provided within 30 days before discharge from the residential SUD facility to support discharge planning. CCS services may not duplicate case management provided by the residential SUD treatment provider.

Managed Care

ForwardHealth expects that most members receiving services through the residential SUD treatment benefit will be enrolled in an HMO. Although the services included in the daily per diem rate will be carved out of the HMO and reimbursed on a fee-for-service basis, members engaged in residential SUD treatment may access other services coverable by the HMO and may be receiving care management from the HMO.

The residential SUD treatment benefit is not covered under Children Come First, Care4Kids, WrapAround Milwaukee, IRIS, Family Care, or Family Care Partnership. Members of those programs would access this benefit via fee-for-service Wisconsin Medicaid.

For members enrolled in an HMO, IRIS, or MCO, residential SUD treatment providers are expected to notify the HMO, IRIS, or MCO of each authorization within 48 hours of the member's admission. Residential providers must also coordinate with the HMO, IRIS consultant agency, or MCO before the member's discharge to develop an appropriate continuing care plan that will support the member's continued recovery effort.

Documentation Retention

Wis. Admin. Code chs. DHS 75, 83, 92, and 94, and 42 C.F.R. Part 2 require residential SUD treatment providers to keep documentation.

Providers are reminded that they must follow documentation retention requirements, per Wis. Admin. Code § DHS 106.02(9). Information about those requirements are explained in the following Online Handbook topics:

- Financial Records topic (#201)
- Medical Records topic (#202)
- Preparation and Maintenance of Records topic (#203)
- Record Retention topic (#204)
- Availability of Records to Authorized Personnel topic (#1640)

Providers are required to produce or submit documentation to ForwardHealth or both upon request. ForwardHealth may deny or recoup payment for services that fail to meet this requirement. Refusal to produce documentation may result in sanctions including, but not limited to, termination from the Medicaid program.

RESOURCES

Refer to the Managed Care section of the Physician service area of the Online Handbook for more general information on Medicaid managed care. Providers can also refer to the Managed Care Organization area of the Portal to access key HMO information.

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Policy Information

To ensure adherence to program requirements, providers should verify that they have the most current sources of policy information. It is critical that providers and staff have access to these documents:

- **Wisconsin Administrative Code**—Wis. Admin. Code chs. DHS 101–108 provides the rules for Medicaid administration.
- **Wisconsin Statutes**—Wis. Stat. ch. 49 provides the legal framework for Wisconsin Medicaid.
- **ForwardHealth Online Handbook**—The Online Handbook has policy information for all providers.

The information provided in this ForwardHealth Update is published in accordance with the policies included in the federally approved BadgerCare Reform 1115 Demonstration Waiver, per s. 20.940(3)(c)(2).

This Update was issued on 12/07/2020 and information contained in this Update was incorporated into the Online Handbook on 02/02/2021.

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 Medicaid Services within the 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 within DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

ATTACHMENT A
Residential Substance Use Disorder Treatment Service Definitions

SERVICE	DEFINITION
Individual counseling/ therapy	The application of recognized theories, principles, techniques, and strategies to facilitate the progress of a patient toward identified treatment goals and objectives
Group counseling/ therapy	The application of counseling techniques that involve interaction among members of a group consisting of at least two patients but not more than 10 patients
Family counseling/ therapy	The application of counseling techniques that involve interaction among members of the patient's family
Psychoeducation	Information provided in a didactic format in either a group or individual setting that relates to health or promotes recovery (Group psychoeducation may not be combined or used interchangeably with group therapy.)
Medication management	Receiving, storing, dispensing, and administering medications to treat the patient's substance use disorder, mental health, and medical conditions
Nursing services	Behavioral health or medical services provided by a nurse licensed under Wis. Stat. ch. 441 and operating within their scope of practice that supports screening, assessment, and treatment for patients
Case management	Planning and coordination of services to meet an individual's identified health needs and assistance provided to the individual for engagement in such services to support the individual's overall treatment and recovery
Peer support services	Supportive strategies rendered by a person with lived experience of mental illness or substance use disorders or both who has completed formal training and holds a peer specialist certification recognized by Wisconsin Medicaid
Recovery coaching	Guidance or support provided to promote engagement in treatment and recovery systems, rendered by an individual who has completed formal, documented training in recovery services

The information provided in this ForwardHealth Update is published in accordance with the policies included in the federally approved BadgerCare Reform 1115 Demonstration Waiver, per s. 20.940(3)(c)(2).

ATTACHMENT B
Enrollment Information

Provider Enrollment

The November 2019 ForwardHealth Update (2019-27), titled "Provider Enrollment Information for the New Residential Facility Substance Use Disorder Treatment Benefit," announced that providers could enroll as residential substance use disorder (SUD) treatment providers. This attachment provides clarification on the existing enrollment information for residential SUD treatment providers. This attachment also outlines the enrollment criteria for all residential SUD treatment provider specialties, including the two new provider specialties; institution for mental disease (IMD) high-intensity services and IMD low-intensity services.

Beginning December 14, 2020, providers will be able to enroll in the following residential SUD treatment provider specialties:

- Clinically Managed High-Intensity Services
- Clinically Managed Low-Intensity Services
- Institution for Mental Disease High-Intensity Services
- Institution for Mental Disease Low-Intensity Services

When selecting a provider specialty, providers should consider the enrollment criteria found on the Information for Specific Provider Types page of the ForwardHealth Portal. Providers can access the Provider Enrollment Information page by visiting the Become a Provider page of the Portal. Providers may contact Provider Services at 800-947-9627 with questions.

Provider Enrollment Criteria

To be eligible for enrollment as a residential SUD treatment provider, Wisconsin Medicaid requires the following:

- Providers must be certified by the Division of Quality Assurance as a medically monitored treatment service and/or as a transitional residential treatment service according to Wis. Admin. Code §§ DHS 75.11 and 75.14. Wisconsin Medicaid will verify Division of Quality Assurance certification upon enrollment.
- Providers must complete and submit a Request for IMD Determination for Residential SUD Facilities, F-02746 (12/2020), form to determine whether the facility meets the definition of an IMD **before** starting the enrollment process. Providers can find the IMD determination form on the Information for Specific Provider Types page of the Portal under the residential SUD provider type.
- When the determination is complete, the provider will receive a determination notice from ForwardHealth. This notice must be submitted at enrollment.

Wisconsin Medicaid Enrollment Process

Provider enrollment in Wisconsin Medicaid is required for reimbursement of services provided to Medicaid or BadgerCare Plus members.

Providers can access more provider enrollment information by visiting the Become a Provider page on the Portal. The Information for Specific Provider Types page of the Portal provides enrollment information specific to residential SUD treatment.

How to Enroll in Wisconsin Medicaid

Existing Medicaid-enrolled providers must submit a new enrollment if they want to apply for this residential SUD treatment category. Before enrolling, providers must be certified by the Division of Quality Assurance.

To enroll in Wisconsin Medicaid as a residential SUD treatment provider, the provider should follow these steps:

1. Access the Portal at https://www.forwardhealth.wi.gov/.
2. Select the Become a Provider link on the left side of the Portal home page. The Provider Enrollment Information home page will be displayed.
3. On the upper left side of the Provider Enrollment Information home page, click Start or Continue Your Enrollment.
4. In the To Start a New Medicaid Enrollment box, click Medicaid/Border Status Provider Enrollment Application.
5. Click **Next** after reading the instructions.
6. Navigate through the enrollment wizard, entering or selecting the applicable information and clicking **Next** to continue.
7. On the Provider Type panel, select **Residential SUD Treatment**.
8. On the Provider Specialty panel, select one of the following, based on Division of Quality Assurance certification and IMD determination:
   - **Clinically Managed High-Intensity Services**
   - **Clinically Managed Low-Intensity Services**
   - **Institution for Mental Disease High-Intensity Services**
   - **Institution for Mental Disease Low-Intensity Services**
9. Continue through the enrollment wizard panels to completion.

Note: Providers may only enroll in one specialty at a time. After they complete enrollment for one specialty, they may enroll a second time for the other specialty. If a provider chooses to enroll in multiple specialties, there will be two separate enrollments.

A provider application fee will be assessed for each provider enrollment application unless the provider paid an application fee to Medicare or another state's Medicaid program.

Enrollment Revalidation

All Medicaid-enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. The provider will also be subject to the application fee when revalidating their enrollment.

During the revalidation process, providers update their enrollment information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation.

In some cases, a site visit may be necessary before enrollment or revalidation.

Notice of Enrollment Decision

ForwardHealth usually notifies the provider of their enrollment status within 10 business days after receiving the **complete** enrollment application. Notification will take no longer than 60 days. Wisconsin Medicaid will either approve or deny the application. Wisconsin Medicaid will enroll the provider if the application is approved. If the enrollment application is denied, Wisconsin Medicaid will give the applicant the reasons for the denial in writing.

Wisconsin Medicaid will send a welcome letter to new Medicaid-enrolled providers. Included with the letter is a copy of the provider agreement and an attachment. The attachment contains important information such as effective dates and the assigned provider type and specialty. This information is used when conducting business with Wisconsin Medicaid. If a provider has multiple enrollments, they will receive a welcome letter for each enrollment.

Effective Date

The first effective date of a provider's enrollment will be based on the date Wisconsin Medicaid receives their completed enrollment application. Wisconsin Medicaid considers an application complete when all required information has been correctly submitted and all supplemental documents have been received.

The date the applicant submits their online provider enrollment application to Wisconsin Medicaid is the earliest effective date possible and will be the effective date if both of the following are true:

- The applicant meets all applicable screening requirements, licensure, certification, authorization, or other credentialing requirements as a prerequisite for Wisconsin Medicaid on the date of submission.
- Supplemental documents required by Wisconsin Medicaid that were not submitted as part of the enrollment process are received by Wisconsin Medicaid within 30 calendar days of the date the enrollment application was submitted. To avoid a delay of the enrollment effective date, providers are encouraged to upload documents during the enrollment process.

If Wisconsin Medicaid receives any applicable supplemental documents more than 30 calendar days after the provider submits the enrollment application, the provider's effective date will be the date all supplemental documents are received by Wisconsin Medicaid.

Establishing a ForwardHealth Portal Account

Establishing a Portal account will allow providers to keep information current with Wisconsin Medicaid. A provider may update information, check a member's eligibility, and bill via the Portal. A Portal account is required for online prior authorization requests, prior authorization amendments, and real-time approval of initial prior authorization requests. To request Portal access and the necessary PIN, complete the following:

1. Access the Portal at https://www.forwardhealth.wi.gov/ and click the Providers icon.
2. In the Quick Links box on the right side of the page, click Request Portal Access. The Request Portal Access page will be displayed.
3. In the NPI Information section, enter the provider's National Provider Identifier (NPI) in the NPI Number field.
4. Click Search. The ForwardHealth Enrollment for Requested NPI section will auto-populate with the provider's information that ForwardHealth has on file. If the NPI is not found, the page will refresh and it will not be populated with the provider's information.
5. Click the appropriate row from the ForwardHealth Enrollment for Requested NPI section. The Selected NPI section will auto-populate with the selected information.
6. Enter the provider's Social Security number (SSN) or Tax Identification Number (TIN) in the SSN or TIN field in the Selected NPI section.
7. Click Submit. If the request is successful, a confirmation page will be displayed.

After a provider successfully requests Portal access, a letter with a PIN will be mailed to the provider. Access to the Portal is **not** possible without a PIN. The letter will also include a Login ID, which is a provider's NPI. For security purposes, the Login ID only has digits three through six of the NPI or Provider ID. Providers should not share their login information with anyone except appropriate staff. It is recommended that providers change their login information when there are staff changes.

Adding Multiple Organizations or Enrollments

Portal users with an administrative account may add multiple organizations to an existing Portal account. This feature offers the ability to manage multiple organizations—or multiple enrollments—within one Portal account. To do so, providers with multiple organizations or enrollments must switch between different organizations or enrollments as appropriate for each transaction. Refer to the ForwardHealth Provider Portal Account User Guide for information on setting up Portal accounts.

Resources

Providers are encouraged to use the various resources intended to help them succeed in doing business with ForwardHealth.

User Guides and Instruction Sheets

Portal user guides and instruction sheets give step-by-step instructions on how to work through various functional areas of the Portal.

Updates and Online Handbook

Updates are the first sources of provider information and announce the latest information on policy and coverage changes.

Changes to policy information are typically included in the Online Handbook in conjunction with published Updates. More information about the addition of the residential SUD treatment benefit will be added to the Online Handbook after coverage of the benefit begins.

Portal Messaging and Email Subscription

ForwardHealth sends Portal account messaging and email subscription messaging to notify providers of newly released Updates.

Providers who have established a Portal account will automatically receive notifications from ForwardHealth in their Portal Messages inbox.

Providers and other interested parties may also register to receive email subscription notifications. Refer to the ForwardHealth Portal Email Subscription User Guide for instructions on how to sign up for email subscriptions.

Provider Services

Providers should call Provider Services at 800-947-9627 for answers to enrollment and policy questions. Provider Services is organized to include program-specific and service-specific assistance to providers.

As a supplement to Provider Services, WiCall is an automated voice response system that allows direct access to enrollment information for providers with touch-tone phones. Providers can reach WiCall at 800-947-3544 and press "1" to begin.