For Wisconsin Medicaid-certified providers

Commonly asked questions about the enhanced Eligibility Verification System

The new Forward ID cards (which will replace the paper Medicaid ID cards) will be the newest way to access Wisconsin Medicaid's Eligibility Verification System (EVS) beginning at the end of July. Providers use EVS to verify recipient eligibility. The following questions were asked by providers during the Forward card training sessions.

Providers may reduce their chances of having a claim denied if they use EVS.

Can I continue to submit electronic claims once the new Forward cards are implemented?
Yes. In fact, Wisconsin Medicaid encourages providers to submit electronic claims because it eliminates manual handling of claims and allows for faster claims processing.

Will the Eligibility Verification System (EVS) speed up the claims submission and payment process?
Yes. Providers may reduce their chances of having a claim denied if they use EVS. You may access EVS through the Forward card magnetic stripe reader or personal computer software to receive up-to-date eligibility information. Providers may purchase the card

reader or software from commercial eligibility verification vendors. Refer to the January 1999 *Medicaid Update* for a list of vendors.

Inside this Update:

Forward card and pharmacy POS pilots will begin in July

Implementation of Wisconsin Medicaid's pharmacy Point of Sale (POS) electronic claims management system is scheduled to begin on July 7, 1999. The new Forward ID cards will be distributed to recipients in pilot counties at the end of July 1999.

Implementation of Wisconsin Medicaid's pharmacy Point of Sale (POS) electronic claims management system and the new Forward ID cards will begin in the following pilot counties:

- Columbia.
- Dane.
- Dodge.
- Green.
- Iowa.
- Jefferson.
- Lafayette.
- Rock.
- Sauk.
- Walworth.

Statewide implementation of POS and the Forward ID cards will be scheduled once the pilot programs are successful.

For more information
For more information on POS and the new Forward cards, refer to Wisconsin Medicaid's web site at *www.dhfs.state.wi.us/medicaid.* You may also contact Provider Services at (800) 947-9627 or (608) 221-9883.

If you choose not to use the card reader or personal computer software, you may use the current methods of accessing EVS, including:

- Automated Voice Response (AVR) system at (800) 947-3544 or (608) 221-4247.

- Direct Information Access Line with Updates for Providers (Dial-Up). Providers may purchase this system from the Medicaid fiscal agent. For more information call (608) 221-4746 and ask for the Electronic Media Claims (EMC) Department.

- Provider Services at (800) 947-9627 or (608) 221-9883.

A chart showing the response information from AVR and commercial eligibility verification vendors is attached to this Update.

What is the process for issuing ID cards for newborns once the new Forward cards are implemented?
Newborns will receive their own Forward card after the fiscal agent receives eligibility information.

Billing procedures for newborns have not changed. If a newborn is issued a temporary number, you may bill with that number even after a permanent number has been issued. Wisconsin Medicaid will cross-reference the temporary and permanent numbers and providers may bill under *either* number.

How often will recipients be notified about which Medicaid managed care program they are in?
Current recipients will receive a notice of which Medicaid managed care program they are enrolled in at initial Forward card implementation. After initial implementation, recipients will receive a notice in the mail about which managed care program they are in upon enrollment in a program or after changing programs. They will also receive a notice when they are disenrolled from a managed care program and placed in fee-for-service. In addition, recipients receive a notice if they become ineligible for Medicaid.

If a recipient changes from one managed care program/HMO to another, will he or she get a new Forward card?
No. Providers should verify eligibility every time they see a recipient to assure they have the most current eligibility information.

Will any of the eligibility verification systems tell who is the recipient's Medicaid HMO primary care provider?
No. Just as before, if the recipient is enrolled in a managed care program, providers will need to contact the HMO directly to determine the recipient's primary care physician. EVS will only give the name and telephone number of the managed care program.

Is the recipient required to sign the signature panel on the back of the Forward card?
No, not at this time. The Forward cards may be used for other programs in the future and signatures may be required then. However, providers may use the signature as a method to positively identify recipients to help deter fraudulent use of the card.

If providers' claims are denied for eligibility reasons, how will they be able to prove that they checked eligibility at the time of service?
The AVR system and services purchased through a commercial eligibility verification vendor (i.e., Forward card reader or computer software) provide a transaction log number specific to each eligibility inquiry. Providers should note and retain these log numbers with their records. Because possession of the plastic card does not guarantee Medicaid eligibility, a

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photocopy of the plastic card will not be acceptable documentation when submitting Good Faith claims.

When using Dial-Up, you may keep a printout of your inquiry. This will show the date and time you verified the recipient's eligibility.

How does other insurance (third-party liability) information get updated?
The fiscal agent updates recipients' files weekly based on information received from the following sources:

- Recipients.
- Providers.
- Eligibility certifying agencies.
- Insurance enrollment tapes from commercial insurance carriers.

Providers should verify eligibility every time they see a recipient to obtain the most current insurance information.

What is the maximum number of transactions that can be done using the AVR system?
Providers are able to make up to eight inquiries per telephone call. ✦

It is critical for health care providers to ensure their systems, equipment, and their vendors are Y2K-ready.

Contingency planning for Y2K issues

Despite all of the best efforts of providers to assure Year 2000 (Y2K)-readiness, disruptions may occur because of issues resulting from Y2K issues. It is important to have contingency plans in place in case computers or electronic equipment fail. The more important the system or equipment, the greater the need for a contingency plan.

Developing a contingency plan
It is critical for health care providers to ensure their systems, equipment, and their vendors are Y2K-ready. It is equally important to prepare for the possibility of others' failures when planning for Y2K. Organizations that supply you with critical goods and services—for example, electricity, water, telecommunications, or fuel—may experience Y2K problems. A contingency plan is not complete unless it addresses these issues.[1]

The focus of contingency planning is to prepare for what might happen if Y2K issues actually occur, despite best efforts to avoid them. Contingency plans are needed in the event you:
- Identify the problem area, fix it, but the fix does not work at the critical time.
- Identify the problem area but cannot fix it (no part available, code missing).
- Are not aware of a problem area, so do not take remedial action.

A contingency plan may include a listing of the following:
- Emergency contacts.
- Key personnel.
- An emergency management team.
- The business functions that can sustain suspended activities.
- A call tree to identify who is notified at the time of an interruption to business.
- An external contacts listing.
- Vital supplies that would be necessary to carry out contingency plans.
- Contingency strategies.
- Continuation/recovery planning strategies.

Determining risk
To determine the risks posed by potential Y2K issues, consider the following questions:

- What functions will be affected if a system or device fails?

- What will be the consequences of the failure?

- Will there be a health and safety, or legal liability for the organization if the system or device fails?

With these questions in mind, organizations and providers must determine which functions need contingency plans, such as computer systems, medical equipment, and billing vendors. A contingency plan template can be found on the Department of Health and Family Services (DHFS) web site at *www.dhfs.state.wi.us/y2k*. Please refer to this template for assistance in developing a contingency plan.

More information

For more information regarding Y2K issues, refer to the Y2K clearinghouse created by the State of Wisconsin. The Y2K clearinghouse can be found at *www.y2k.state.wi.us*. If you have specific Medicaid Y2K questions, please call (608) 221-4746, extension 3705. Please leave your name, your question, and a telephone number where you can be reached, and someone will contact you.

[1] This information is excerpted from the Department of Health and Family Services' (DHFS) *Year 2000 Millennium Countdown Guide for Health and Human Service Providers*. This guide was previously sent to providers and is also available on the DHFS web site. Please refer to this guide for a detailed discussion of Y2K contingency planning. ✦

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our web site at *www.dhfs.state.wi.us/medicaid*.

What's new on the Medicaid web site

The Wisconsin Medicaid web site includes provider and recipient publications, Medicaid contacts and statistics, and eligibility and benefit information. The following is a list of what has recently been added to the Medicaid web site.

You may visit the Medicaid web site at *www.dhfs.state.wi.us/Medicaid.*

- Presumptive eligibility statistics. Presumptive eligibility is temporary Medicaid eligibility for pregnant women so they may receive immediate ambulatory prenatal care, and it is a preliminary determination of Medicaid eligibility, including Healthy Start.

- Federal poverty levels. The federal poverty level is one of the factors for determining eligibility for Medicaid and other assistance programs. The federal poverty level changes on an annual basis.

- All caseload statistics from 1993 through 1999. These statistics include the number of eligible individuals who may receive Medicaid services. Statistics are shown by county, month, and year, with statewide totals. These will be updated monthly.

- *Forward* newsletter. This provides information about Wisconsin Medicaid managed care initiatives and other issues affecting Wisconsin Medicaid.

Keep in mind that if you do not have a computer with Internet access, many schools and libraries have access. ✦

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Reference guide to responses from AVR and commercial eligibility verification vendors

To access the fiscal agent's Automated Voice Response (AVR) system, call (800) 947-3544 or (608) 221-4247.

Providers may also access the Eligibility Verification System (EVS) from the recipient's Forward card by using a magnetic stripe reader (point-of-service device or terminal) or personal computer software. The following chart shows the response information AVR and commercial eligibility verification vendors give to providers. In addition to the information listed below, through AVR providers may inquire about Checkwrite information, claim status, and prior authorization request status.

Differences between the two verification methods are in *italics*.

AVR Eligibility Response Includes:	Commercial Eligibility Verification Vendor Response Includes:
Audio **response** *only.*	*Printed transaction* **response** *for your records.*
Transaction log number to keep for records.	**Transaction log number** to keep for records.
Recipient information: • Medicaid ID number. • Date of birth.	**Recipient information:** • Medicaid ID number. • *Name.* • Date of birth. • *Sex.* • *Recipient medical status code.*
Eligibility information for the current date and previous 12 months.	**Eligibility information** for the current date and previous 12 months.
Special medical status messages (if applicable).	**Special medical status** messages (if applicable).
Health Personnel Shortage Area (HPSA) message (if applicable).	**Health Personnel Shortage Area** (HPSA) message (if applicable).
Medicaid managed care messages: • Managed care program two-digit code. • Managed care program name. • Managed care 24-hour telephone number. • Included services: chiropractic, dental, neither or both.	**Medicaid managed care** messages: • Managed care program two-digit code. • Managed care program name. • Managed care 24-hour telephone number. • Included services: chiropractic, dental, neither or both.
Medicare messages: • Coverage description: Part A, Part B, or Parts A and B. • Medicare health insurance care (HIC) number.	**Medicare** messages: • Coverage description: Part A, Part B, or Parts A and B. • Medicare health insurance care (HIC) number.
Lock-in messages (if applicable): • Lock-in effective dates. • Multiple categories of service: pharmacy, physician, dental, HealthCheck, outpatient hospital, medical vendor, institution, hospice.	**Lock-in** messages (if applicable): • Lock-in effective dates. • Multiple categories of service: pharmacy, physician, dental, HealthCheck, outpatient hospital, medical vendor, institution, hospice.
Multiple third party liability (private insurance) messages: • Coverage effective dates. • *Coverage type: medical, dental, verified pharmacy, or combination.* • Coverage indicator: HMO, HMP, HPP, BLU, WPS, CHA, OTH, or DEN. • Carrier name, address, and *telephone number.* • *Recipient's relationship to insured: self, spouse, etc.* • Policyholder's Social Security number. • Policy and group numbers.	**Multiple third party liability (private insurance)** messages: • Coverage effective dates. • *Coverage type: pharmacy, physician, dental, inpatient hospital, outpatient hospital, nursing home, vision, DME rental, DME purchase, home health.* • Coverage indicator: HMO, HMP, HPP, BLU, WPS, CHA, OTH, or DEN. • Carrier *code*, name, and address. • Policyholder's Social Security number *and name*. • Policy and group numbers.