# All Provider

# Recipient Eligibility

## ARCHIVAL USE ONLY
## Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

# Contacting Wisconsin Medicaid

| **Web Site** | ***dhfs.wisconsin.gov/*** |
|---|---|
| The Web site contains information for providers and recipients about the following:<br>• Program requirements.<br>• Publications.<br>• Forms.<br>• Maximum allowable fee schedules.<br>• Professional relations representatives.<br>• Certification packets. | Available 24 hours a day, seven days a week |
| **Automated Voice Response System** | **(800) 947-3544**<br>**(608) 221-4247** |
| The Automated Voice Response system provides computerized voice responses about the following:<br>• Recipient eligibility.<br>• Prior authorization (PA) status.<br>• Claim status.<br>• Checkwrite information. | Available 24 hours a day, seven days a week |
| **Provider Services** | **(800) 947-9627**<br>**(608) 221-9883** |
| Correspondents assist providers with questions about the following:<br>• Clarification of program requirements.<br>• Recipient eligibility.<br>• Resolving claim denials.<br>• Provider certification. | Available:<br>8:30 a.m. - 4:30 p.m. (M, W-F)<br>9:30 a.m. - 4:30 p.m. (T)<br>Available for pharmacy services:<br>8:30 a.m. - 6:00 p.m. (M, W-F)<br>9:30 a.m. - 6:00 p.m. (T) |
| **Division of Health Care Financing**<br>**Electronic Data Interchange Helpdesk** | **(608) 221-9036**<br>**e-mail: *wiedi@dhfs.state.wi.us*** |
| Correspondents assist providers with *technical* questions about the following:<br>• Electronic transactions.<br>• Companion documents.<br>• Provider Electronic Solutions software. | Available 8:30 a.m. - 4:30 p.m. (M-F) |
| **Web Prior Authorization Technical Helpdesk** | **(608) 221-9730** |
| Correspondents assist providers with Web PA-related *technical* questions about the following:<br>• User registration.<br>• Passwords.<br>• Submission process. | Available 8:30 a.m. - 4:30 p.m. (M-F) |
| **Recipient Services** | **(800) 362-3002**<br>**(608) 221-5720** |
| Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following:<br>• Recipient eligibility.<br>• General Medicaid information.<br>• Finding Medicaid-certified providers.<br>• Resolving recipient concerns. | Available 7:30 a.m. - 5:00 p.m. (M-F) |

# Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

| Certification and Ongoing Responsibilities |
|---|
| • Certification and recertification.<br>• Change of address or status.<br>• Documentation requirements.<br>• Noncertified providers.<br>• Ongoing responsibilities.<br>• Provider rights.<br>• Provider sanctions.<br>• Recipient discrimination prohibited.<br>• Release of billing information. |

| Claims Information |
|---|
| • Follow-up procedures.<br>• Good Faith claims.<br>• Preparing and submitting claims.<br>• Reimbursement information.<br>• Remittance information.<br>• Submission deadline.<br>• Timely filing appeals requests. |

| Coordination of Benefits |
|---|
| • Commercial health insurance.<br>• Crossover claims.<br>• Medicare.<br>• Other Coverage Discrepancy Report, HCF 1159.<br>• Primary and secondary payers.<br>• Provider-based billing. |

| Covered and Noncovered Services |
|---|
| • Collecting payment from recipients.<br>• Covered services.<br>• Emergency services.<br>• HealthCheck "Other Services."<br>• Medical necessity.<br>• Noncovered services. |



| Informational Resources |
|---|
| • Electronic transactions.<br>• Eligibility Verification System.<br>• Maximum allowable fee schedules.<br>• Forms.<br>• Medicaid Web site.<br>• Professional relations representatives.<br>• Provider Services.<br>• Publications. |

| Managed Care |
|---|
| • Covered and noncovered HMO and SSI MCO services.<br>• Enrollee HMO and SSI MCO eligibility.<br>• Enrollment process.<br>• Extraordinary claims.<br>• HMO and SSI MCO claims submission.<br>• Network and non-network provider information.<br>• Provider appeals. |

| Prior Authorization |
|---|
| • Amending prior authorization (PA) requests.<br>• Appealing PA decisions.<br>• Grant and expiration dates.<br>• Prior authorization for emergency services.<br>• Recipient loss of eligibility during treatment.<br>• Renewal requests.<br>• Review process.<br>• Submitting PA requests. |

| Recipient Eligibility |
|---|
| • Copayment requirements.<br>• Eligibility categories.<br>• Eligibility responsibilities.<br>• Eligibility verification.<br>• Identification cards.<br>• Limited benefit categories.<br>• Misuse and abuse of benefits.<br>• Retroactive eligibility. |

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# Preface

This All-Provider Handbook is issued to all Medicaid-certified providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.



Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of this handbook for information about state-contracted managed care organizations.

## Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/*.
- *dhfs.wisconsin.gov/badgercare/*.

## Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

## Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

# Eligibility Categories

To reduce claim denials, providers should always verify a recipient's eligibility before providing services to determine eligibility for the current date (since a recipient's eligibility status may change) and to discover any limitations to the recipient's coverage.

Recipient eligibility issues are the primary reason claims are denied by Wisconsin Medicaid. To reduce claim denials, providers should always verify a recipient's eligibility before providing services to determine eligibility for the current date (since a recipient's eligibility status may change) and to discover any limitations to the recipient's coverage.

Some recipients are not entitled to receive full Medicaid benefits and may only receive limited services. Most recipients, whether they are eligible for all services or limited services, receive a Forward card. Recipients are encouraged to keep their Forward cards during periods of ineligibility. Possession of a Forward card does not guarantee that a recipient is eligible for Wisconsin Medicaid.



Providers should refer clients who want more information on Medicaid eligibility to one of the following:

- Their local county/tribal social or human services agency.
- Recipient Services at (800) 362-3002 or (608) 221-5720.
- The Recipient section of the Medicaid Web site.

## Medicaid Recipients

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, or T19.

A Medicaid recipient is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in Chapter 49, Wis. Stats.

Wisconsin Medicaid eligibility is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be eligible for Wisconsin Medicaid if he or she is in one of the following categories:

- Age 65 and older.
- Blind or disabled.
- Under age 19.
- Pregnant.
- A relative caretaker of a child under age 18 or a dependent 18-year old.

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Healthy Start.
- Katie Beckett.
- Medicaid Purchase Plan.
- Subsidized adoption and foster care programs.
- Supplemental Security Income.
- Wisconsin Well Woman Program (WWWP).

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid eligibility:

- County/tribal social or human services agencies.
- Medicaid outstation sites.
- Social Security Administration offices.

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid, including the Department of Health and Family Services' Division of Children and Family Services.

Medicaid fee-for-service recipients receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid recipients receive services through state-contracted managed care organizations.

Providers should refer to the Recipient section of the Medicaid Web site for the most current eligibility requirements and Medicaid certifying agencies.

## BadgerCare Recipients

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185 percent of the Federal Poverty Level (FPL) who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance. For the most current eligibility requirements, refer to the BadgerCare Web site at *dhfs.wisconsin.gov/badgercare/*.

Currently, to be eligible for BadgerCare, family members must be uninsured and ineligible for full-benefit Medicaid. BadgerCare covers the following individual family members who meet low-income financial and nonfinancial requirements:

- Children under age 19 (regardless of whether or not they are living with their parents).
- Parents living with their children under age 19.
- Spouse of a parent of children under age 19.

Once eligible, families may remain eligible for BadgerCare until their family income exceeds 200 percent of the FPL. No asset test is required. Adult BadgerCare applicants and recipients are required to verify their earnings and health insurance access/coverage with their employer as a condition of BadgerCare eligibility.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system. Providers should submit claims for BadgerCare recipients the same way they submit claims for Medicaid recipients.

Most BadgerCare recipients receive services through Medicaid HMOs or SSI MCOs. These state-contracted managed care organizations receive a capitation payment for each recipient. Some BadgerCare recipients receive services through Medicaid fee-for-service.

Although Medicaid publications refer to Medicaid recipients, the information applies to BadgerCare recipients also.



## Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by the WWWP or the Family Planning Waiver Program (FPWP), meet all other eligibility requirements, and are in need of treatment for any of the following:

- Breast cancer.
- Cervical cancer.
- Precancerous conditions of the cervix.

Services provided to women who are eligible for Well Woman Medicaid are reimbursed through Medicaid fee-for-service.

Refer to the Wisconsin Well Woman Medicaid provider page of the Medicaid Web site for more information.

Although Medicaid publications refer to Medicaid recipients, the information applies to BadgerCare recipients also.

# Limited Benefit Categories

Certain Medicaid recipients are eligible for only limited Medicaid benefits even though they may present a Forward identification card. These limited benefit categories include:

Certain Medicaid recipients are eligible for only limited Medicaid benefits even though they may present a Forward identification card.

- Family Planning Waiver Program, including the Presumptive Eligibility (PE) for the FPWP.
- Presumptive Eligibility for Pregnant Women Benefit.
- Tuberculosis-Related Services-Only (TB-Only) Benefit.
- Qualified Medicare Beneficiary Only (QMB Only).
- Specified Low-Income Medicare Beneficiary (SLMB).
- Qualifying Individuals 1 (QI-1).
- Qualified Disabled Working Individuals (QDWI).



Providers are strongly encouraged to verify dates of eligibility and other coverage information using the Medicaid Eligibility Verification System (EVS) to determine whether a recipient is in a limited benefit category or receives full-benefit Medicaid. Refer to Appendix 1 of this section for a summary of the limited benefit categories. Refer to the Eligibility Verification Methods chapter of this section for more information on using the EVS.

Providers are responsible for knowing which services are covered under a limited benefit category. If a recipient of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the recipient if certain conditions are met. Refer to the Covered and Noncovered Services section of this handbook for information about collecting payment from recipients.

## Family Planning Waiver Program

The FPWP is a limited benefit category that provides routine contraceptive-related services to low-income women who are otherwise not eligible for Wisconsin Medicaid or BadgerCare. Recipients receiving FPWP services must be receiving routine contraceptive-related services.

Recipients enrolled in the FPWP receive routine services to prevent or delay pregnancy. Only services *clearly* related to contraceptive management are covered under the FPWP. Family Planning Waiver Program recipients are not eligible for other services that are covered under full-benefit Medicaid and BadgerCare (e.g., physical therapy services, dental services). They are also not eligible for other family planning services that are covered under full-benefit Wisconsin Medicaid and BadgerCare (e.g., mammograms and hysterectomies). If a medical condition, other than a sexually transmitted disease (STD), is discovered during contraceptive-related services, treatment for the medical condition is not covered under the FPWP.

Colposcopies and treatment for STDs are only covered through the FPWP if they are determined medically necessary during routine contraceptive-related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the recipient is in the FPWP and receiving contraceptive-related services.

Family Planning Waiver Program recipients diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible recipients with the enrollment process for Well Woman Medicaid.

For more information about the FPWP, including covered services, refer to the Medicaid Web site.

### *Presumptive Eligibility for the Family Planning Waiver Program*

Women whose providers are submitting an initial FPWP application on their behalf and who meet the eligibility criteria may receive

routine contraceptive-related services immediately through PE for the FPWP for up to three months. Services covered under PE for the FPWP are the same as those covered under the FPWP and must be clearly related to routine contraceptive management.

Presumptive Eligibility for the FPWP providers may issue white paper PE for the FPWP temporary identification cards for women to use until they receive a Forward card. Refer to the Medicaid Identification Cards chapter of this section for more information. Providers should remind women that the benefit is temporary, despite their receiving a Forward card.

For more information about PE for the FPWP, including covered services, refer to the Medicaid Web site.

### Presumptive Eligibility for Pregnant Women Benefit

The PE for Pregnant Women Benefit is a limited benefit category that allows an uninsured or underinsured (i.e., insured without prenatal coverage) pregnant woman to receive Medicaid-covered pregnancy-related *outpatient* services while her application for full-benefit Medicaid is processed.

Presumptive eligibility providers may issue beige paper PE for pregnant women temporary identification cards for women to use until they receive a Forward card. Refer to the Medicaid Identification Cards chapter of this section for more information.

Refer to the Guide to Determining Presumptive Eligibility for Pregnant Women Benefit for more information about recipient eligibility criteria, applications, and covered services.

### Tuberculosis-Related Services-Only Benefit

The TB-Only Benefit is a limited benefit category that allows individuals with the TB infection or disease to receive Medicaid-covered TB-related outpatient services.

Recipients of the TB-Only Benefit receive a Forward identification card. Refer to the Medicaid Identification Cards chapter of this section for more information.

Refer to the Guide to the Tuberculosis-Related Services-Only Benefit for more information about recipient eligibility for the TB-Only Benefit and covered services.

### Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary-Only recipients are a limited benefit category of Medicaid recipients. The only benefits they receive from Wisconsin Medicaid are payment of the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.

Qualified Medicare Beneficiary-Only recipients are certified by their county/tribal social or human services agency. Qualified Medicare Beneficiary-Only recipients are required to meet the following qualifications:

- Have an income under 100 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Not be receiving other Medicaid benefits.

Qualified Medicare Beneficiary-Only recipients receive a Forward identification card. Refer to the Medicaid Identification Cards chapter of this section for more information.



The PE for Pregnant Women Benefit is a limited benefit category that allows an uninsured or underinsured (i.e., insured without prenatal coverage) pregnant woman to receive Medicaid-covered pregnancy-related *outpatient* services while her application for full-benefit Medicaid is processed.

Specified Low-Income Medicare Beneficiary recipients, Qualifying Individual 1 recipients, and Qualifying Disabled Working Individual recipients do not receive a Medicaid identification card.

## Specified Low-Income Medicare Beneficiaries

Specified Low-Income Medicare Beneficiary recipients are a limited benefit category of Medicaid recipients. The only benefits they receive from Wisconsin Medicaid are payment of Medicare monthly premiums for Part B.

Specified Low-Income Medicare Beneficiary recipients are certified by their county/tribal social or human services agency. To qualify, SLMB recipients are required to meet the following qualifications:

- Have an income under 120 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for other regular Wisconsin Medicaid benefits.

Specified Low-Income Medicare Beneficiary recipients do not receive a Medicaid identification card.



## Qualifying Individual 1 Recipients

Qualifying Individual 1 recipients are a limited benefit category of Medicaid recipients. The only benefit they receive from Wisconsin Medicaid is payment of Medicare monthly premiums for Part B.

Qualifying Individual 1 recipients are certified by their county/tribal social or human services agency. To qualify, QI-1 recipients are required to meet the following qualifications:

- Have income between 120 and 135 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets that are too high to qualify for other regular Wisconsin Medicaid benefits.

Qualifying Individual 1 recipients do not receive a Medicaid identification card.

## Qualified Disabled Working Individual Recipients

Qualifying Disabled Working Individual recipients are a limited benefit category of Medicaid recipients. The only benefit they receive from Wisconsin Medicaid is payment of Medicare monthly premiums for Part A.

Qualified Disabled Working Individual recipients are certified by their county/tribal social or human services agency. To qualify, QDWI recipients are required to meet the following qualifications:

- Have income under 200 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for other regular Wisconsin Medicaid benefits, including QMB Only and SLMB.

Qualifying Disabled Working Individual recipients do not receive a Medicaid identification card.

# Medicaid Identification Cards



It is possible that a recipient will present a card when he or she is not eligible; therefore, it is essential that providers confirm eligibility before providing services.

It is important that providers determine a recipient's Medicaid eligibility, managed care enrollment, and other insurance coverage *prior to* each date of service (DOS) that services are provided. Pursuant to HFS 104.02(2), Wis. Admin. Code, except in emergencies that preclude prior identification, a recipient should inform providers that he or she is eligible for Wisconsin Medicaid and should present a current Medicaid identification card before receiving services.

*Note:* Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, durable medical equipment suppliers, independent laboratories, and ambulances — are not always able to see a recipient's Medicaid identification card because they might not have direct contact with the recipient prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain recipient eligibility information.



Wisconsin Medicaid recipients receive a Medicaid identification card upon initial eligibility determination. Medicaid identification cards may be in any of the following formats:

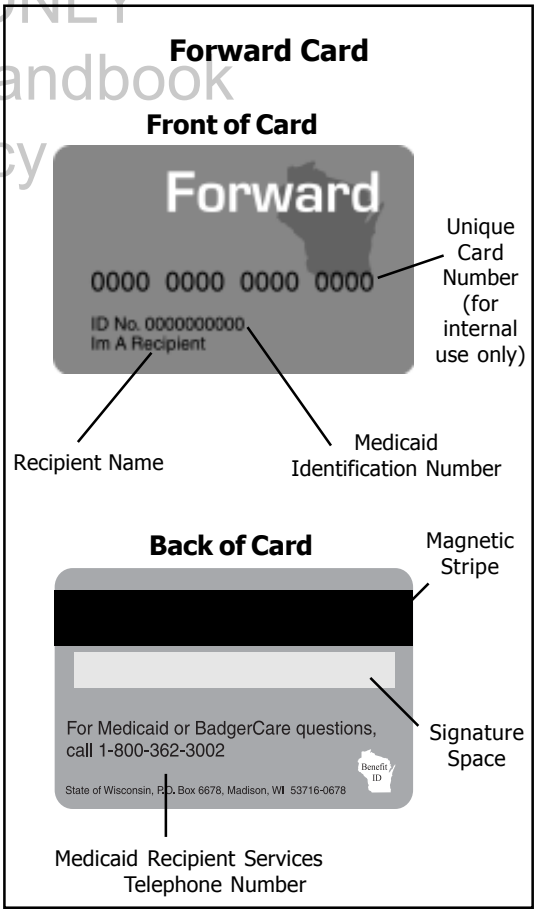
- Blue plastic Forward cards.
- Green paper temporary cards.
- Beige paper Presumptive Eligibility (PE) for Pregnant Women Benefit cards.
- White paper PE for the Family Planning Waiver Program (FPWP) cards.

## Forward Cards

The Forward card is the standard card issued to recipients who are eligible for Wisconsin Medicaid and BadgerCare. *Possession of a Forward card does not guarantee eligibility.* Periodically, recipients may become ineligible for Wisconsin Medicaid only to regain eligibility at a later date. It is possible that a recipient will present a card when he or she is not eligible; therefore, it is essential that providers confirm eligibility before providing services. Wisconsin Medicaid encourages recipients to keep their cards even though they may have periods of ineligibility.

If the card is lost, stolen, or damaged, Wisconsin Medicaid will replace the card at no cost to the recipient.

If a family has more than one eligible recipient, each eligible family member receives a Forward card.



## Forward Card Features

The Forward card includes the recipient's name, 10-digit Medicaid identification number, magnetic stripe, signature panel, and the Medicaid Recipient Services telephone number. The card also has a unique, 16-digit card number on the front. This number is for internal use only and is not used for submitting claims.

The Forward card does not need to be signed to be valid. However, adult recipients are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of the card is for recipient use only.

The address on the back of the card is used to return the card to Wisconsin Medicaid if it is lost.

If a provider finds discrepancies with the identification number or name between what is indicated on the Forward card and the provider's file, the provider should verify eligibility with the Medicaid Eligibility Verification System (EVS). Refer to the Eligibility Verification Methods chapter of this section for more information on the EVS.

## Identification Number Changes

Some providers may question whether services should be provided if a recipient's 10-digit Medicaid identification number on his or her Forward card does not match the EVS response. If the EVS indicates the recipient is eligible, services should be provided.

A recipient's identification number may change and the EVS will reflect that change. However, Wisconsin Medicaid does not automatically send a replacement Forward card with the new identification number to the recipient. Wisconsin Medicaid cross-references the old and new identification numbers so a provider may submit claims with either number. The recipient may request a replacement Forward card that indicates the new number.

## Recipient Name Changes

If a recipient's name on the Forward card is different than the EVS, providers should use the name from the EVS response. When a name change is reported and on file, Wisconsin Medicaid automatically sends a new Forward card to the recipient.

## Deactivated Cards

When a Forward card has been replaced for any reason, the original card is deactivated. Providers should encourage the recipient to discard the deactivated card and use only his or her new card.

If a provider finds that a Forward card has been *deactivated* and the provider does not know the recipient, the provider may request a second form of identification from the recipient. After the recipient's identity has been verified, providers may check the recipient's Medicaid eligibility by using one of the EVS methods such as Automated Voice Response.



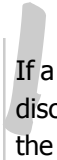
## Defective Cards

If a provider swipes a Forward card and the magnetic stripe is defective, the provider should encourage the recipient to call Medicaid Recipient Services to request a new card. The provider should consult with his or her vendor for messages that may be displayed on the magnetic stripe card reader after a defective card is used.

If a recipient presents a Forward card with a *defective* magnetic stripe, providers may verify the recipient's eligibility by using one of the EVS methods, such as Automated Voice Response. Providers may also verify a recipient's eligibility by calling Provider Services at (800) 947-9627 or (608) 221-9883.

## Lost Cards

If a recipient lost his or her Forward card or never received one, the recipient may call



If a provider finds discrepancies with the identification number or name between what is indicated on the Forward card and the provider's file, the provider should verify eligibility with the Medicaid Eligibility Verification System (EVS).

Recipient Services (800) 362-3002 or (608) 221-5720 to request a new one.

### Managed Care Organization Enrollment Changes

Recipients do not receive a new Forward card if they are enrolled in a state-contracted managed care organization (MCO) or change from one MCO to another. Providers should verify eligibility with the EVS every time they see a recipient to ensure they have the most current managed care enrollment information.

Providers should accept temporary cards as proof of eligibility. Eligible applicants may receive Medicaid-covered services for the dates shown on the card.

## Temporary Medicaid Cards

All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet Medicaid eligibility requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the Forward card. Providers should accept temporary cards as proof of eligibility. Eligible applicants may receive Medicaid-covered services for the dates shown on the card.



Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the eligibility start date until the eligibility information is transmitted to Wisconsin Medicaid.

Wisconsin Medicaid accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS is within the dates shown on the card.

If Wisconsin Medicaid denies a claim with an eligibility-related explanation, even though the provider verified the recipient's eligibility before providing the service, a good faith claim may be submitted. Refer to the Claims Information section of this handbook for more information about submitting good faith claims.

## Presumptive Eligibility for Pregnant Women Temporary Cards

Presumptive eligibility providers may issue beige paper PE for pregnant women temporary identification cards for women to use until they receive a Forward card. The identification card is included with the Presumptive Eligibility for Pregnant Women Application, HCF 10081. The PE for Pregnant Women Benefit cards have the following message printed on them: "Outpatient Pregnancy-Related Care." The PE provider should indicate the dates of eligibility on the card. Providers should accept the card as proof of eligibility for those dates.

Providers are encouraged to keep a photocopy of the PE card.

Refer to the Guide to Determining Presumptive Eligibility for Pregnant Women for more information.

## Presumptive Eligibility for the Family Planning Waiver Program Temporary Cards

Qualified providers may issue white paper PE for the FPWP identification cards for women to use temporarily until they receive a Forward card. The identification card is included with the Presumptive Eligibility for the Family Planning Waiver Program application, HCF 10119. The PE for the FPWP identification cards have the following message printed on them: "Wisconsin Medicaid Presumptive Eligibility for the Family Planning Waiver Temporary Identification Card." The PE for the FPWP provider indicates the dates of eligibility on the card. Providers should accept the card as proof of eligibility for those dates.

Providers are encouraged to keep a photocopy of the PE for the FPWP card.

Refer to the Medicaid Web site for more information on the FPWP.

# Eligibility Verification Methods

Accessing the EVS ensures that providers receive the most current eligibility information available.

Medicaid providers should *always* verify a recipient's eligibility before providing services, both to determine eligibility for the current date (since a recipient's eligibility status may change) and to discover any limitations to the recipient's coverage. Providers may want to verify the recipient's eligibility a second time before submitting a claim to find out whether the recipient's eligibility information has changed since the appointment.

Providers have several options to obtain eligibility information through the Medicaid Eligibility Verification System (EVS). Each eligibility verification method allows providers to obtain recipient information, including:

- Limited benefit categories.
- Health Professional Shortage Area coverage.
- Lock-In status.
- Recipient liability.
- Level of care.
- Medicare coverage.
- Medicaid managed care coverage.
- Commercial health insurance coverage.



Accessing the EVS ensures that providers receive the most current eligibility information available. Providers can access the EVS through the following methods:

- 270/271 Health Care Eligibility/Benefit Inquiry and Response (270/271) transactions.
- Automated Voice Response (AVR) system.
- Commercial eligibility verification vendors (accessed through software, magnetic stripe card readers, and the Internet).
- Provider Services at (800) 947-9627 or (608) 221-9883.

Providers cannot charge a recipient, or authorized person acting on behalf of the recipient, for verifying his or her eligibility.

## 270/271 Transactions

The 270/271 transactions allow for batch eligibility verification, including information for the current benefit month and previous 365 days, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a recipient's eligibility. The 271 is received in response to the inquiry. Refer to the Informational Resources section of this handbook for more information about electronic transactions.

## Automated Voice Response System

Providers may obtain information from the AVR system by calling (800) WIS-ELIG (947-3544) or (608) 221-4247. The AVR system is a computerized service that allows providers with touch-tone telephones direct access to eligibility information for the current benefit month and previous 365 days. It also allows providers to access provider checkwrite information, claim status information, and prior authorization status information. Providers are able to make up to eight inquiries per call.

The AVR system features:

- Easy-to-follow prompts.
- Toll-free telephone lines.
- The option to select "0" to transfer to Provider Services.

The AVR system issues a six-character transaction verification number every time a provider verifies eligibility, even when an individual is *not* eligible for Wisconsin Medicaid. The provider should retain this transaction verification number. It is proof that

an inquiry was made about the recipient's eligibility. If a provider thinks a claim was denied in error, the provider can reference the transaction verification number to Wisconsin Medicaid to confirm the eligibility response that was actually given.

An AVR Quick Reference Guide that indicates the strings to be entered for abbreviated entry to the AVR system is included in Appendix 2 of this section.

### Dates of Service

For eligibility information about a previous date *and* the current date, two inquiries are often better than one since providers making one inquiry for a range of dates will receive eligibility information for months which may not be of interest.

Generally providers cannot request eligibility information for future dates of service (DOS). However, after the 20th of the month, eligibility status for the current month and the upcoming month is available.

### Hours

The AVR system is normally available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers should call Provider Services during regular business hours.

## Commercial Eligibility Verification Vendors

Wisconsin Medicaid has certified several commercial eligibility verification vendors to offer real-time eligibility verification technology to Medicaid providers. Commercial eligibility verification vendors have up-to-date access to the Medicaid eligibility files to ensure that providers have access to the most current eligibility information. Providers may access the EVS to verify recipient eligibility through one or more of the following methods available from commercial eligibility verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Providers may access eligibility information through these methods 24 hours a day, seven days a week. Refer to Appendix 3 of this section for a list of commercial eligibility verification vendors that sell these services.

The real-time eligibility verification methods allow providers to print a paper copy of the recipient's eligibility information, including a six-character transaction verification number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

### Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. They use the magnetic stripe on the back of the Forward card to access current Medicaid eligibility information.

Providers receive current recipient eligibility information after passing the Forward card through the reader or entering the recipient identification number or card number into a keypad and entering the DOS about which they are inquiring.

### Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

### Internet Access

Some eligibility verification vendors provide real-time access to eligibility from the EVS through the Internet.

Commercial eligibility verification vendors have up-to-date access to the Medicaid eligibility files to ensure that providers have access to the most current eligibility information.

Even if a recipient does not present a Medicaid identification card, a provider can use the EVS to verify eligibility, or the provider may choose not to provide the service(s) until a recipient brings in an identification card.

## Provider Services

Providers can make eligibility inquiries by calling Provider Services at (800) 947-9627 or (608) 221-9883 during business hours. When providers call Provider Services, they are asked to select "1" for recipient eligibility information. Providers who do not have touch-tone telephones should stay on the line for assistance from a correspondent.

Providers can obtain eligibility information beyond 365 days prior to current DOS and other recipient information not available through the other EVS methods.

Providers are able to make three eligibility inquiries per call.

### Hours

Providers may call Provider Services during the following hours for recipient eligibility information:

- 8:30 a.m. to 4:30 p.m. on Mondays, Wednesdays, Thursdays, and Fridays.
- 9:30 a.m. to 4:30 p.m. on Tuesdays.



## Recipient Forgets Identification Card

Even if a recipient does not present a Medicaid identification card, a provider can use the EVS to verify eligibility, otherwise, the provider may choose not to provide the service(s) until a recipient brings in an identification card.

A provider may use a combination of the recipient's name, date of birth, Medicaid identification number, or Social Security number with a "0" at the end to access eligibility information through the EVS.

A provider may call Provider Services with the recipient's full name and date of birth to obtain the recipient's eligibility information if the recipient's identification number or Social Security number is not known.

# Eligibility Rights

An applicant for Wisconsin Medicaid has the right to request retroactive coverage when applying for Wisconsin Medicaid.

Medicaid recipients are entitled to certain rights per HFS 103, Wis. Admin. Code. This chapter contains information on recipient rights pertaining to eligibility.

## Prompt Decisions on Eligibility

Individuals applying for Wisconsin Medicaid have the right to prompt decisions on their applications. Eligibility decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

## Requesting Retroactive Eligibility



An applicant for Wisconsin Medicaid has the right to request retroactive coverage when applying for Wisconsin Medicaid. Wisconsin Medicaid coverage may be backdated to the first of the month three months prior to the date of application for eligible recipients. Retroactive coverage does not apply to BadgerCare or Qualified Medicare Beneficiary-Only recipients. Refer to the Special Eligibility Circumstances chapter of this section for more information on retroactive eligibility.

## Appealing Eligibility Determinations

Applicants and recipients have the right to appeal certain decisions relating to Medicaid eligibility. An applicant for Wisconsin Medicaid, a Medicaid recipient, or authorized person acting on behalf of the applicant or recipient, or former recipient may file the appeal with the Division of Hearings and Appeals (DHA).

Pursuant to HA 3.03, Wis. Admin. Code, an applicant, recipient, or former recipient may appeal any adverse action or decision by an agency or department which affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for Wisconsin Medicaid was denied.
- Application for Wisconsin Medicaid was not acted upon promptly.
- Eligibility was unfairly discontinued, terminated, suspended, or reduced.

In the case when Medicaid eligibility is cancelled or terminated, the date the recipient, or authorized person acting on behalf of the recipient, files an appeal with the DHA determines what continuing coverage, if any, the recipient will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a recipient who files an appeal:

- If a recipient files an appeal before his or her eligibility ends, Medicaid coverage will continue pending the hearing decision.
- If a recipient files an appeal within 45 days after his or her eligibility ends, a hearing is allowed but Medicaid coverage is not reinstated.

If the recipient files an appeal more than 45 days after his or her eligibility ends, a hearing is not allowed.

Recipients may file an appeal by submitting a Request for Fair Hearing form, DHA-28, which is available on the Forms page of the Recipient section of the Medicaid Web site.

### Claims for Appeal Reversals

If Wisconsin Medicaid denies a claim due to termination of eligibility, a hearing decision that reverses Medicaid's determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the recipient, attach the copy to the previously denied claim, and submit both to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

If a provider has not yet submitted a claim to Wisconsin Medicaid, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions. Refer to the Claims Information section of this handbook for more information.

## Freedom of Choice

Recipients may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted managed care organization or assigned to the Recipient Lock-In Program. Refer to the Misuse and Abuse of Benefits chapter for information about the Recipient Lock-In Program.

Recipients may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted managed care organization or assigned to the Recipient Lock-In Program.

## Notification of Discontinued Benefits

When the Department of Health and Family Services (DHFS) intends to discontinue, suspend, or reduce a recipient's Medicaid benefits, or reduce or eliminate coverage of services for a general class of recipients, the DHFS sends a written notice to recipients. This notice is required to be provided at least 10 days before the effective date of the action.

# Eligibility Responsibilities

Except in emergencies that preclude prior identification, recipients are required to inform providers that they are receiving benefits under Wisconsin Medicaid and must present their Medicaid identification card before receiving care.

Medicaid recipients have certain responsibilities per HFS 104.02, Wis. Admin. Code, and the Medicaid Eligibility and Benefits booklet, PHC 10025. This chapter contains information on recipient responsibilities pertaining to eligibility.

## Prior Identification of Eligibility

Except in emergencies that preclude prior identification, recipients are required to inform providers that they are receiving benefits under Wisconsin Medicaid and must present their Medicaid identification card before receiving care. Refer to the Eligibility Verification Methods chapter of this section for more information about how to verify eligibility if a recipient forgets his or her Medicaid identification card.



## Loss of Medicaid Eligibility — Financial Liability

Some Medicaid-covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a recipient loses eligibility for Wisconsin Medicaid midway through treatment, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided after eligibility has lapsed.

Recipients are financially responsible for any services received after their Wisconsin Medicaid eligibility has been terminated. If the recipient wishes to continue treatment, it is a decision between the provider and the recipient whether the service should be given and how the services will be paid. The provider may collect payment from the recipient if the recipient accepts responsibility for payment of a service and certain conditions are met. Refer to the Covered and Noncovered Services section of this handbook for more information.

To avoid misunderstandings, it is recommended that providers remind recipients that they are financially responsible for any continued care after eligibility ends.

*Note:* Exceptions to the loss of eligibility in mid-treatment include dental prosthodontia or orthodontic treatment. Providers of these services should refer to their service-specific publications for more information on these exceptions.

Other types of providers should not assume Wisconsin Medicaid covers completion of services after the recipient's eligibility has been terminated.

To avoid potential reimbursement problems that can arise when a recipient loses eligibility midway through treatment, the provider is encouraged to verify the recipient's eligibility using the Medicaid Eligibility Verification System (EVS) prior to providing each service, even if an approved prior authorization request is obtained for the service. Refer to the Eligibility Verification Methods chapter of this section for more information about the EVS.

## Reporting Changes to Caseworkers

Recipients are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state.
- A change in income.
- A change in family size, including pregnancy.
- A change in other health insurance coverage.
- Employment status.
- A change in assets for recipients who are over 65 years of age, blind, or disabled.

# Copayment Requirements

Providers are required to request copayments from recipients; however, they may not deny services to a recipient who fails to make a copayment.

Federal law permits states to charge recipients copayments for certain covered services. Providers are required to request copayments from recipients; however, they may not deny services to a recipient who fails to make a copayment.

Chapter 49.45(18), Wis. Stats., requires providers to make a reasonable attempt to collect copayment from the recipient unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

For additional information on copayments, providers should refer to their service-specific publications.



## Copayment Exemptions

According to HFS 104.01(12), Wis. Admin. Code, providers are prohibited from collecting copayment from the following recipient groups:

- Recipients under 18 years old. (For HealthCheck services, recipients under 19 years old are exempt.)
- Recipients in nursing homes.
- Recipients in state-contracted managed care organizations receiving managed care-covered services. Refer to the Managed Care section of this handbook for more information.
- Pregnant women who receive medical services related to their pregnancy or to another medical condition that may complicate their pregnancy.

The following services do not require copayment:

- Case management services.
- Community support program services.
- Crisis intervention services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- Private duty nursing and respiratory care services.
- School-based services.
- Substance abuse day treatment services.
- Surgical assistance.

## Copayment Amounts

For most services, copayment amounts are based on Medicaid's reimbursement amount for each procedure code. Medicaid's reimbursement amounts for procedure codes are listed in service-specific maximum allowable fee schedules which are on the Medicaid Web site.

The following copayment amounts apply for most services; however, providers should refer to their service-specific publications for specific copayment requirements, including copayment amounts.

| Medicaid Reimbursement (per procedure code) | Copayment |
|---|---|
| Up to $10.00 | $0.50 |
| From $10.01 to $25.00 | $1.00 |
| From $25.01 to $50.00 | $2.00 |
| Over $50.00 | $3.00 |

## Copayment Limitations

Providers should verify that they are collecting the correct copayment for services as some services have monthly or annual copayment limits. Providers may not collect recipient copayments in amounts that exceed Medicaid

copayment limits. Providers should refer to their service-specific publications for copayment limits.

## Copayment Refund/ Collection Requirement

If a provider collects a copayment before providing a service and Wisconsin Medicaid does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copayment amount to the recipient.

If Wisconsin Medicaid deducts less copayment than the recipient paid, the provider is required to return or credit the remainder to the recipient. If Wisconsin Medicaid deducts more copayment than the recipient paid, the provider may collect the remaining amount from the recipient.

# Special Eligibility Circumstances

## Retroactive Eligibility

The retroactive eligibility period may be backdated up to three months prior to the month of application if all eligibility requirements were met during the period.

Retroactive eligibility occurs when an individual has applied for Wisconsin Medicaid and eligibility is granted with an effective date prior to the date the eligibility determination was made. A recipient's Medicaid eligibility may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive eligibility period may be backdated up to three months prior to the month of application if all eligibility requirements were met during the period. Eligibility may be backdated more than three months if there were delays in determining eligibility or if court orders, fair hearings, or appeals were involved.



*Note:* Retroactive eligibility does not apply to BadgerCare recipients.

### Reimbursing Recipients in Cases of Retroactive Eligibility

When a recipient receives retroactive eligibility, he or she has the right to request the return of payments made to a Medicaid-certified provider for a Medicaid-covered service during the period of retroactive eligibility, according to HFS 104.01(11), Wis. Admin. Code. A Medicaid-certified provider is required to submit claims to Wisconsin Medicaid for covered services provided to a recipient during periods of retroactive eligibility. Wisconsin Medicaid cannot directly refund the recipient.

If a service(s) that requires prior authorization (PA) was performed during the recipient's period of retroactive eligibility, the provider is required to submit a PA request and receive approval from Wisconsin Medicaid *before* submitting a claim. Refer to the Prior Authorization section of this handbook for more information on requesting PA for recipients with retroactive eligibility.

If a provider receives reimbursement from Wisconsin Medicaid for services provided to a retroactively eligible recipient and the recipient has paid for the service, the provider is required to reimburse the recipient or authorized person acting on behalf of the recipient (e.g., local General Relief agency) no less than the amount paid by Wisconsin Medicaid. The provider is not required to reimburse the recipient more than the amount paid by Wisconsin Medicaid according to HFS 106.04(3)(b), Wis. Admin. Code.

*For example:* A provider receives $100 from a client for a given service. One month later, the client is granted retroactive eligibility for Wisconsin Medicaid for the previous dates of service (DOS). The provider submits a claim and is reimbursed $62 by Wisconsin Medicaid. (This total is reached by taking the maximum allowable fee [$65] minus the applicable copayment [$3].) The provider is then required to refund the $62 to the recipient.

If a claim cannot be filed within 365 days of the DOS due to a delay in the determination of a recipient's retroactive eligibility, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive eligibility is entered into the Medicaid Eligibility Verification System (if the services provided during the period of retroactive eligibility were Medicaid covered). Refer to the Claims Information section of this handbook for more information on filing claims for services performed with DOS beyond the claims submission deadline (timely filing appeals requests).

## Spenddown to Meet Medicaid Financial Eligibility Requirements

Occasionally, an individual with significant medical bills meets all Medicaid eligibility requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet Medicaid's financial eligibility requirements.

The certifying agency calculates the individual's Medicaid spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies Wisconsin Medicaid and the provider of the last service that the individual is Medicaid eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for Wisconsin Medicaid as of the DOS on the last bill.
- A claim for the service(s) on the last bill should be submitted to Wisconsin Medicaid. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs Wisconsin Medicaid of the individual's eligibility and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.
- The Medicaid provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim to Wisconsin Medicaid, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Recipient's Share element on the Medicaid Remaining Deductible Update form, HCF 10109, sent to providers by the recipient's certifying agency. The provider's reimbursement is then reduced by the amount of the recipient's obligation.



## Persons Detained by Legal Process

An individual detained by legal process is *not* eligible for Wisconsin Medicaid benefits. "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. The justice system oversees health care-related needs for individuals detained by legal process.

An individual detained by legal process is *not* eligible for Wisconsin Medicaid benefits. "Detained by legal process" means a person who is incarcerated (including Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners.

## Recipients Traveling Out of State

When a recipient travels out of state but is within the United States (including its territories), Canada, or Mexico, Wisconsin Medicaid covers medical services in any of the following circumstances:

- An emergency illness or accident.
- When the recipient's health would be endangered if treatment were postponed.

- When the recipient's health would be endangered if travel to Wisconsin were undertaken.
- When PA has been granted to the out-of-state provider for provision of a nonemergency service.
- The coinsurance, copayment, and deductible amount remaining after Medicare payment or approval for dual eligibles.

*Note:* Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid certified as a border-status provider if the provider notifies Wisconsin Medicaid in writing that it is common practice for recipients in a particular area of Wisconsin to seek his or her medical services. Border-status providers follow the same policies as Wisconsin Medicaid providers. Refer to the Certification and Ongoing Responsibilities section of this handbook for more information about border-status providers.

Certain non-U.S. citizens who are not qualified aliens are eligible for Wisconsin Medicaid services only in cases of acute emergency medical conditions.



## Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for Wisconsin Medicaid services only in cases of acute emergency medical conditions. Providers should use the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Due to federal regulations, Wisconsin Medicaid does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the county/tribal social or human services agency or Medicaid outstation site for a determination of Wisconsin Medicaid eligibility. Providers may complete the Certification of Emergency for Non-U.S. Citizens form, HCF 1162, for clients to take to the county/tribal social or human services agency in their county of residence where the Medicaid eligibility decision is made. The completion instructions and the Certification of Emergency for Non-U.S. Citizens form are located in Appendices 4 and 5 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Providers should be aware that a client's eligibility does not guarantee that the services provided will be reimbursed by Wisconsin Medicaid.

## Medicaid Recipients from Other States

Wisconsin Medicaid does not pay for services provided to recipients enrolled in other state Medicaid programs.

Refer to the National Association of State Medicaid Directors Web site at *www.nasmd.org/members.htm* for a current list of state Medicaid programs. Providers are advised to contact these offices to determine whether the service sought is a covered service under that state's Medicaid program.

# Misuse and Abuse of Benefits

Providers are required to notify Wisconsin Medicaid if they have reason to believe that a person is misusing or abusing Medicaid benefits or the Medicaid identification card.

Providers are required to notify Wisconsin Medicaid regarding suspected cases of recipient misuse or abuse of Medicaid benefits. Section 49.49, Wis. Stats., defines actions that represent recipient misuse or abuse of Medicaid benefits and the resulting sanctions that may be imposed.

## Examples of Misuse and Abuse

The following are examples of recipient abuse or misuse included in HFS 104.02(5), Wis. Admin. Code:

- Altering or duplicating the Medicaid identification card in any manner.
- Permitting card use by an unauthorized individual for the purpose of obtaining services through Wisconsin Medicaid.
- Using a Medicaid identification card that belongs to another recipient.
- Using a Medicaid identification card to obtain any covered service for another individual.
- Duplicating or altering prescriptions.
- Knowingly misrepresenting material facts as to medical symptoms for the purpose of obtaining any covered service.
- Knowingly furnishing incorrect eligibility status or other information to a provider.
- Knowingly furnishing false information to a provider in connection with health care previously rendered that the recipient has obtained and for which Wisconsin Medicaid has been billed.
- Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care that is clearly not medically necessary.
- Knowingly obtaining duplicate services through more than one provider for the same health care condition, excluding confirmation of diagnosis or a second opinion on surgery.
- Otherwise obtaining health care by false pretenses.



## Requesting Additional Proof of Identity

Providers may request additional proof of identity from a recipient if they suspect fraudulent use of a Medicaid identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the Medicaid identification card if it is signed. (Wisconsin Medicaid encourages adult recipients to sign the back of their cards; however, it is not mandatory for recipients to do so.)

Verifying recipient identity, as well as eligibility, can help providers detect instances of fraudulent identification card use. For more information on methods of verifying recipient eligibility through the Medicaid Eligibility Verification System, refer to the Eligibility Verification Methods chapter of this section.

## Notifying Wisconsin Medicaid

Providers are required to notify Wisconsin Medicaid if they have reason to believe that a person is misusing or abusing Medicaid benefits or the Medicaid identification card. Providers are under no obligation to inform the recipient that they are doing so. A provider may not confiscate an identification card from a recipient in question.

If a provider suspects that a recipient is abusing his or her Medicaid benefits or misusing his or her Medicaid identification

card, providers are required to notify Wisconsin Medicaid by calling Provider Services at (800) 947-9627 or (608) 221-9883 or by writing to the following office:

Division of Health Care Financing
Bureau of Health Care Program Integrity
PO Box 309
Madison WI 53701-0309

Wisconsin Medicaid monitors recipient records and can impose sanctions on those who misuse or abuse their benefits. For more information on recipient misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

## Providers May Refuse to Provide Services

Providers may refuse to provide services to a Medicaid recipient in situations when there is reason to believe that the person presenting the Medicaid identification card is misusing or abusing it.

Recipients who abuse or misuse Wisconsin Medicaid benefits or their Medicaid identification card may have their benefits terminated or be subject to limitations under the Recipient Lock-In Program or to criminal prosecution.

## Recipient Lock-In Program

If Wisconsin Medicaid determines that a recipient is abusing Medicaid services, the recipient may be required to designate a health care provider under the Recipient Lock-In Program. (A recipient has the right to appeal this action.) Recipients are required to designate, in any or all categories of health care, a Medicaid-certified provider of their choice. If a recipient fails to choose a provider, Wisconsin Medicaid may designate one based on claims data.

Wisconsin Medicaid notifies the recipient's chosen health care provider by letter. Another letter is also sent to the recipient. The provider has the option to decline to act as the selected health care provider for the recipient.

A recipient in the Lock-In Program who has already designated a provider can only receive the locked-in services from his or her designated provider. A provider who is *not* the designated provider of a Lock-In Program recipient for the locked-in services should *not* perform services for that recipient unless a referral is in place from the Lock-In provider.

Claims for restricted, nonemergency services performed by a provider who is not the designated provider are reviewed by Wisconsin Medicaid and may be denied.

Providers may obtain Lock-In information by using any of the eligibility verification methods. To obtain the name of the designated Lock-In provider, call Provider Services.



### Providers May Make Referrals

The designated Lock-In provider may make referrals to other providers of medical services. Wisconsin Medicaid supplies Lock-In Program providers with referral forms that should be used when it is necessary to refer the recipient to another provider.

Reimbursement is made if the referral can be documented as medically necessary and the services are covered by Wisconsin Medicaid.

Providers may receive reimbursement for emergency services given without a referral to a locked-in recipient if the claim is accompanied by a full explanation of the emergency circumstances.

The designated provider is required to maintain all appropriate documentation in the recipient's medical records.

If Wisconsin Medicaid determines that a recipient is abusing Medicaid services, the recipient may be required to designate a health care provider under the Recipient Lock-In Program.

# Appendix



ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

# Appendix 1
# Limited Benefit Categories

Certain Medicaid recipients are only eligible for limited benefits. Providers are required to verify dates of eligibility and other coverage on the Medicaid Eligibility Verification System to determine whether a recipient is eligible for one of the following limited benefit categories:

- Family Planning Waiver Program (FPWP).
- Presumptive Eligibility (PE) for the FPWP.
- Presumptive Eligibility for Pregnant Women Benefit.
- Tuberculosis-Related Services-Only (TB-Only) Benefit.
- Qualified Medicare Beneficiary Only (QMB Only).
- Specified Low-Income Medicare Beneficiary (SLMB).
- Qualifying Individuals 1 (QI-1) (also known as SLMB+).
- Qualified Disabled Working Individuals (QDWI).

*Note:* Federal Poverty Level (FPL) income limits change annually. Refer to the Medicaid Web site at *dhfs.wisconsin.gov/medicaid1/fpl/fpl.htm* for FPL guidelines.



| Category | Medicaid Identification Card | Income Requirements | Coverage Needed for Recipient to Qualify | Wisconsin Medicaid Benefits |
|---|---|---|---|---|
| FPWP | Forward card | Under 185 percent of the FPL | N/A | Routine contraceptive-related services and supplies to low-income women who are otherwise not eligible for Wisconsin Medicaid or BadgerCare |
| PE for the FPWP | Forward card or white paper temporary card | Under 185 percent of the FPL | N/A | Routine contraceptive-related services and supplies to low-income women who are otherwise not eligible for Wisconsin Medicaid or BadgerCare |
| PE for Pregnant Women Benefit | Forward card or beige paper temporary card | Under 185 percent of the FPL | N/A | Pregnancy-related outpatient services |
| TB-Only Benefit | Forward card | Twice the federal Supplemental Security Income (SSI) benefit amount (Refer to the Social Security Web site at *www.ssa.gov/* for more information on SSI.) | N/A | Medicaid-covered outpatient services only |
| QMB Only* | Forward card | Under 100 percent of the FPL | Must be entitled to, but not necessarily enrolled in, Medicare Part A | Medicare premium for Part A and Part B (if required)<br>Coinsurance, copayment, and deductible for Medicare-allowed services |
| SLMB* | None | Under 120 percent of the FPL (Income or assets are too high to qualify for other Medicaid benefits.) | Must be entitled to, but not necessarily enrolled in, Medicare Part A | Medicare Part B premium |



*Coverage is limited to out-of-pocket Medicare-related Part A and/or Part B costs only. No additional Medicaid services are covered.

| Category | Medicaid Identification Card | Income Requirements | Coverage Needed for Recipient to Qualify | Wisconsin Medicaid Benefits |
|---|---|---|---|---|
| QI-1* | None | Between 120 and 135 percent of the FPL (Income or assets are too high to qualify for other Medicaid benefits.) | Must be entitled to, but not necessarily enrolled in, Medicare Part A | Medicare Part B premium |
| QDWI* | None | Under 200 percent of the FPL (Income or assets are too high to qualify for other Medicaid benefits, including QMB Only and SLMB.) | Must be entitled to, but not necessarily enrolled in, Medicare Part A | Medicare Part A premium |

*Coverage is limited to out-of-pocket Medicare-related Part A and/or Part B costs only. No additional Medicaid services are covered.

# Appendix 2

# Quick-Entry Guide for the Automated Voice Response System

The following entry strings can be used to check eligibility on the Automated Voice Response (AVR) system quickly. Information on the chart that is shown between brackets ( [ ] ) is entry information specific to the provider, recipient, or date(s). Numerical values and the pound sign (#) indicate direct telephone keypad entries. Information may be entered prior to voice prompts, as long as it is entered in the appropriate sequence. At any point during the voice prompts, providers may skip to the next segment of information by pressing "1."

Generally, providers cannot request eligibility information for future dates. However, if the provider verifies eligibility for the current date and this date is after the 20th of the month, eligibility for the following month and the current month may be provided. Providers may obtain information from the AVR system by calling (800) WIS-ELIG (947-3544) or (608) 221-4247.

| Type of Eligibility Search | Entry String |
|---|---|
| Current date by entering a recipient identification number | 1, 1, [provider number], #, 1, 1, [recipient identification number], #, 1, #, # |
| Current date by entering the recipient's date of birth (DOB) and Social Security number (SSN) | 1, 1, [provider number], #, 1, 2, [DOB — MMDDCCYY], #, 1, [SSN], #, 1, #, # |
| Specific date by entering a recipient identification number | 1, 1, [provider number], #, 1, 1, [recipient identification number], #, 1, [date from — MMDDCCYY], #, [date to — MMDDCCYY], # |
| Specific date by entering DOB and SSN | 1, 1, [provider number], #, 1, 2, [DOB — MMDDCCYY], #, 1, [SSN], #, 1, [date from — MMDDCCYY], #, [date to — MMDDCCYY] |

# Appendix 3
# Eligibility Verification Vendors

Wisconsin Medicaid has certified several eligibility verification vendors that offer real-time, up-to-date access to Wisconsin Medicaid eligibility files to ensure that providers have access to the most current recipient eligibility information.

These vendors sell magnetic stripe card readers, personal computer software, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Medicaid providers are responsible for the costs of using these eligibility verification methods.

*Note:* Providers are *not* required to purchase services from a commercial eligibility verification vendor. For more information on other ways to verify recipient eligibility or for questions about the Forward cards, contact Provider Services at (800) 947-9627 or (608) 221-9883 or visit the Medicaid Web site.

For more information regarding the card readers or software, contact a vendor from the following list. Providers may call more than one vendor to obtain a variety of price quotations. For the most current listing, refer to the Medicaid Web site.

| Name | Address | Telephone/Fax | Web Address |
|---|---|---|---|
| Healthcare Data Exchange, LLC | 65 Valley Stream Pkwy<br>Malvern PA 19355 | (610) 219-1600<br>Fax (610) 219-1384 | *www.hdx.com/* |
| Medifax-EDI℠, Inc. | 1283 Murfreesboro Rd<br>Nashville TN 37217 | (800) 444-4336 | *www.medifax.com/* |
| Passport Health Communications, Inc. | 720 Cool Springs Blvd<br>Ste 450<br>Franklin TN 37067 | (888) 661-5657<br>(615) 661-5657<br>Fax (615) 376-3552 | *www.passporthealth.com/* |
| UW Proservices Health Information Technologies | 400 N Executive Dr<br>Ste 311<br>Brookfield WI 53005 | (800) 822-8050<br>Fax (262) 364-0235 | *www.uwproservices.com/* |
| Emdeon Corporation | 669 River Dr<br>Center 2<br>Elmwood Park NJ 07407 | (201) 703-3400<br>Fax (201) 703-3401 | *www.webmd.com/corporate/* |
| Wisconsin Health Information Network (WHIN) | 11217 W Forest Home Ave<br>Franklin WI 53132 | (800) 331-9446<br>(414) 448-1100<br>Fax (414) 448-1202 | *www.whin.net/* |
| Independent Physicians Network | Ste 300<br>6767 W Greenfield Ave<br>Milwaukee WI 53214 | (414) 771-6177<br>Fax (414) 771-1159 | *www.ipn-wi.com/* |

# Appendix 4

## Certification of Emergency for Non-U.S. Citizens Form Completion Instructions





(A copy of the Certification of Emergency for Non-U.S. Citizens Form Completion Instructions is located on the following pages.)

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# WISCONSIN MEDICAID
# CERTIFICATION OF EMERGENCY FOR NON-U.S. CITIZENS COMPLETION INSTRUCTIONS

## SERVICES FOR NON-U.S. CITIZENS

The use of this form is not mandatory, but by verifying that the service(s) provided was to treat an emergency medical condition (according to the federal definition below), the provider is helping the county/tribal social or human services agency determine Wisconsin Medicaid eligibility for certain non-U.S. citizens.

Under 8 USC 1611(b)(1)(A), certain non-U.S. citizens are not eligible for Wisconsin Medicaid services except when those services are necessary for the treatment of an emergency medical condition. Title 42 CFR s. 440.255(c)(1) law describes an emergency medical condition as follows:

> A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> - Placing the patient's health in serious jeopardy;
> - Serious impairment to bodily functions; or
> - Serious dysfunction of any bodily organ or part.

Per federal regulations, Wisconsin Medicaid does not cover services related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For purposes of this policy, all labor and delivery is considered emergency labor and delivery.

## MEDICAID ELIGIBILITY

Do not complete this form if the patient is already eligible for Wisconsin Medicaid. To determine whether a patient is a Medicaid recipient, contact the Medicaid Eligibility Verification System (EVS). For more information about the EVS, refer to the Informational Resources section of the All-Provider Handbook. Providers also have the option of calling Provider Services at (800) 947-9627 or (608) 221-9883 to determine the eligibility status of a patient.



*Note:* A provider's certification of "emergency" does not guarantee Wisconsin Medicaid reimbursement.

## PATIENT INFORMATION

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible patients.

Patients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, and address (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

## INSTRUCTIONS

After the provider has completed the form, the patient should take this form to the county/tribal social or human services agency in his or her county of residence where the decision of eligibility is made. Wisconsin Medicaid advises providers to keep a copy for their records. Medicaid reimbursement for the emergency service is conditional on meeting all program rules, including meeting the definitions of emergency medical condition, as described above, and medical necessity.

## SECTION I — PATIENT INFORMATION

**Element 1 — Name — Patient**
Enter the patient's last name, first name, and middle initial.

**Element 2 — Address — Patient**
Enter the complete address (street, city, state, and zip code) of the patient's place of residence.

**Element 3 — Date of Birth — Patient**
Enter the birth date of the patient.

**Element 4 — Social Security Number — Patient**
This information is not required. Most non-U.S. citizens do not have Social Security numbers (SSN). If provided, the SSN will only be used for the administration of Wisconsin Medicaid.

**Element 5 — Emergency Start Date**
Enter the start date, in MM/DD/YYYY format, in which the patient was initially treated for the emergency condition.

**Element 6 — Emergency End Date**
Enter the date, in MM/DD/YYYY format, in which the patient's condition was no longer considered an emergency condition (according to the federal definition) or the date in the future, in the provider's judgment, that the emergency condition will end.

**Element 7 — Name — Contact Person**
Enter the name of the person who can verify the information provided on this form.

**Element 8 — Telephone Number — Contact Person**
Enter the telephone number of the contact person, including area code.

**SECTION II — PROVIDER INFORMATION AND AUTHORIZATION**

**Element 9 — Name — Provider**
Print the medical provider's name or the name of the facility where treatment was provided.

**Element 10 — Signature — Provider**
The form must be signed by the performing physician, physician assistant, nurse practitioner, nurse midwife, or dentist who can verify that the patient was treated for an emergency medical condition according to the federal definition.

**Element 11 — Date Signed**
Enter the date the form is signed.

## Appendix 5
## Certification of Emergency for Non-U.S. Citizens (for photocopying)





(A copy of the Certification of Emergency for Non-U.S. Citizens is located on the following page.)

**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF1162 (Rev. 08/05)

## WISCONSIN MEDICAID
# CERTIFICATION OF EMERGENCY FOR NON-U.S. CITIZENS

After the provider completes the form, the patient should take this form to the county/tribal social or human services agency in his or her county of residence where the decision of eligibility is made. Wisconsin Medicaid advises providers to keep a copy for their records. Medicaid reimbursement for the emergency service is conditional on meeting all program rules, including the definition of an emergency medical condition as described in the instructions. Before completing this form, read the Certification of Emergency for Non-U.S. Citizens Completion Instructions (HCF 1162A).

**SECTION I — PATIENT INFORMATION**

| | |
|---|---|
| 1. Name — Patient | 2. Address — Patient |
| 3. Date of Birth — Patient | 4. Social Security Number — Patient |
| 5. Emergency Start Date | 6. Emergency End Date |
| 7. Name — Contact Person | 8. Telephone Number — Contact Person |



**SECTION II — PROVIDER INFORMATION AND AUTHORIZATION**

I verify that the above-named patient was treated for an emergency medical condition as defined under 42 CFR s. 440.255(c)(1).

9. Name — Provider (Print)

| | |
|---|---|
| 10. **SIGNATURE** — Provider | 11. Date Signed |

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