Review of the Explanation of Medical Benefits Form

Brown Bag Lunch Series
Maria Schwartz ::: October 24, 2017
Agenda

- General policy information
- Impacted paper claim forms
- Revised forms and instructions
- Reminders regarding ink, data alignment, and quality standards
- Section-by-section breakdown
General Policy Information

- Effective August 3, 2015, the Explanation of Medical Benefits form, F-01234, must be included for each other payer indicated on the paper claim or claim adjustment:
  - For professional and institutional paper claims and claims adjustments
  - Regardless of the date of service or date of discharge
- The Explanation of Medical Benefits form requirement applies to paper claims and adjustments submitted to Wisconsin Medicaid, BadgerCare Plus, and the Wisconsin Chronic Disease Program (WCDP).
General Policy Information (Cont.)

- Providers are reminded that, except for a few instances, Wisconsin Medicaid, BadgerCare Plus, and WCDP are payers of last resort for any covered service.

- Providers are required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted managed care organization.
General Policy Information (Cont.)

- Use of the ForwardHealth Explanation of Medical Benefits form is mandatory; providers are required to use an exact copy.
- ForwardHealth will not accept alternate versions (i.e., retyped, or otherwise reformatted) of the Explanation of Medical Benefits form.
- Submitting the Explanation of Medical Benefits form with paper claims and adjustments will ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or via the 837 Health Care Claim electronic transactions, including those submitted using Provider Electronic Solutions (PES) software, a clearinghouse, or a software vendor.
Impacted Paper Claim Forms

The Explanation of Medical Benefits form will be required with all of the following paper claim forms if other health insurance sources are indicated:

- 1500 Health Insurance Claim Forms and adjustments
- UB-04 Claim Forms and adjustments
- 1500 and UB-04 claims and adjustments submitted with a Timely Filing Appeals form, F-13047
- 1500 and UB-04 claims and adjustments submitted that require special handling
- Medicare crossover claims
Revised Forms and Instructions

Effective August 2015, the following forms and their corresponding completion instructions have been revised as a result of the Explanation of Medical Benefits form requirements:

- Adjustment/Reconsideration Request form, F-13046
- Timely Filing Appeals Request form
Reminders

- In order for the Optical Character Recognition software to read paper claim forms accurately, the claim forms and the Explanation of Medical Benefits form must comply with:
  - Certain ink standards
  - Other data alignment standards
  - Quality standards
- Refer to the Paper Claim Form Preparation and Data Alignment Requirements topic (topic #561) in the ForwardHealth Online Handbook for more information.
Section I — Payer Information

| 1. | Medicare | Medicare Advantage | Commercial Insurance |

- Check the appropriate box to indicate whether the primary payer is Medicare, Medicare Advantage, or commercial insurance.
- If commercial insurance, enter the name of the commercial insurance.
Section II — Member Information

<table>
<thead>
<tr>
<th>Element 2 — Name — Member</th>
<th>Element 3 — Member ID/HICN</th>
<th>Element 4 — Relationship to Policyholder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the last name, first name, and middle initial of the member.</td>
<td>Enter the 10-digit Medicaid member ID.</td>
<td>Indicate the member’s relationship to the policyholder.</td>
</tr>
<tr>
<td>This number must correspond with the member ID on the 1500 Health Insurance Claim Form or UB-04 (CMS 1450) Claim Form as well as any additional Explanation of Medical Benefits forms.</td>
<td>If the details continue onto page 2 of the Explanation of Medical Benefits form, enter the member ID listed in this element in the space provided at the top of the page.</td>
<td></td>
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</tbody>
</table>
Section III — Primary Policyholder Information

<table>
<thead>
<tr>
<th>Section III — PRIMARY POLICYHOLDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Name — Primary Policyholder (Last Name, First Name, Middle Initial)</td>
</tr>
</tbody>
</table>

- Element 5 — **Name — Primary Policyholder** — Enter the name of the primary payer policyholder.
- Element 6 — **Primary Policy ID/HICN** — Enter the primary payer policyholder’s ID number or Health Insurance Claim Number.
- Element 7 — **Policy/Group Number** — Enter the primary payer policyholder’s policy or group number.
Section IV — Header Adjudication Information

Providers are required to complete Section IV of the Explanation of Medical Benefits form if the primary payer processed the claim at the header level.

If the primary payer did not supply header-level information, this section may be left blank.
Section IV — Header Adjudication Information (Cont.)

- If this section is left blank, providers are required to complete Section V.
- The claim will be returned to the provider unprocessed if both Sections IV and V of the Explanation of Medical Benefits form are left blank.

*Note:* Professional crossover claims require both the header and the detail information to process the claim.
Section V — Detail Adjudication Information

<table>
<thead>
<tr>
<th>SECTION V — DETAIL ADJUDICATION INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. To Date of Service</td>
</tr>
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</table>

- Providers are required to complete this section if the primary payer processed the claim at the detail level.
- If the primary payer did not supply detail-level information, providers may leave this section blank.
- If this section is left blank, providers are required to complete Section IV.

Note: Professional crossover claims require both the header and the detail information to process the claim.
Thank You