Claims

1

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Claims:Adjustment Requests

Topic #814

Allowed Claim

An allowed claim (or adjustment request) contains at least one service that is reimbursable. Allowed claims display on the Paid Claims Section of the RA (Remittance Advice) with a dollar amount greater than "0" in the allowed amount fields. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

Topic #815

Denied Claim

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Topic #512

Electronic

837 Transaction

Even if the original claim was submitted on paper, providers may submit electronic adjustment requests using an 837 (837 Health Care Claim) transaction.

Provider Electronic Solutions Software

The Wisconsin DHS (Department of Health Services) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim to adjust. Once the claim is found, the provider can alter it to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid within 365 days of the DOS (date of service) can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Claim adjustments with DOS beyond the 365-day submission deadline should **not** be submitted electronically. Providers who attempt to submit a claim adjustment electronically for DOS beyond 365 days will have the entire amount of the claim recouped.

Requests for adjustments to claims with DOS beyond the 365-day submission deadline may be submitted using the timely filing process (a paper process) if the claim adjustment meets one of the exceptions to the claim submission deadline.

Topic #513

Follow-Up

Providers who believe an error has occurred or their issues have not been satisfactorily resolved have the following options:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI (Electronic Data Interchange) Helpdesk for assistance with electronic adjustment requests.

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (02/2025)) form.

Topic #816

Processing

Within 30 days of receipt, ForwardHealth generally reprocesses the original claim with the changes indicated on the adjustment request and responds on ForwardHealth remittance information.

Topic #514

Purpose

After reviewing both the claim and ForwardHealth remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors
- To correct inappropriate payments (overpayments and underpayments)
- To add and delete services
- To supply additional information that may affect the amount of reimbursement
- To request professional consultant review (for example, medical, dental)

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to ForwardHealth.

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

Providers may submit paper attachments to accompany electronic claim adjustments. Providers should refer to their companion guides for directions on indicating that a paper attachment will be submitted by mail.

Good Faith Claims

Topic #518

Definition of Good Faith Claims

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS (Enrollment Verification System) and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

When a member presents a temporary ID card for EE (Express Enrollment) in BadgerCare Plus or Family Planning Only Services but the member's enrollment is not on file yet in the EVS, the provider should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If, after two days, the EVS indicates that the member still is not enrolled or the claim is denied with an enrollment-related EOB (Explanation of Benefits) code, the provider should contact Provider Services for assistance.

When a member who received a real-time eligibility determination presents a temporary ID card but the member's enrollment is not on file yet in the EVS, the provider should wait up to one week to submit a claim to ForwardHealth. If the claim is denied with an enrollment-related EOB code, the provider should contact Provider Services for assistance.

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to ForwardHealth in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since both of the following are true:

- A cash refund does not provide documentation for provider records as an adjustment request does. (Providers may be required to submit proof of the refund at a later time.)
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

Topic #532

Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels.

ForwardHealth processes an adjustment request if the provider is all of the following:

- Medicaid-enrolled on the DOS (date of service).
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under Wis. Admin. Code § DHS 106.08.
- Claiming and receiving ForwardHealth reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

Wisconsin Medicaid will deduct the overpayment when the electronic adjustment request is processed. Providers should use the companion guide for the appropriate 837 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

For paper adjustment requests, providers are required to do the following:

- Submit an Adjustment/Reconsideration Request (F-13046 (02/2025)) form through normal processing channels (not timely filing), regardless of the DOS
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim

After the paper adjustment request is processed, Wisconsin Medicaid will deduct the overpayment from future reimbursement amounts.

Topic #533

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA (Remittance Advice) for the claim to be adjusted and highlight the affected claim on the RA. If a copy of the RA is not available, providers should indicate the ICN (internal control number), the NPI (National Provider Identifier) (if applicable), and the payee ID from the RA for the claim to be adjusted. The check should be sent to the following address:

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

Topic #531

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If ForwardHealth initiates an adjustment to recover overpayments, ForwardHealth remittance information will include details of the adjustment in the Claims Adjusted Section of the paper RA (Remittance Advice).

Topic #530

Requirements

As stated in Wis. Admin. Code § DHS 106.04(5), the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from ForwardHealth or other health insurance sources.

In the case of all other overpayments (for example, incorrect claims processing, incorrect maximum allowable fee paid), providers are required to return the overpayment within 30 days of the date of discovery.

The return of overpayments may occur through one of the following methods:

- Return of overpayment through the adjustment request process
- Return of overpayment with a cash refund
- Return of overpayment with a voided claim
- ForwardHealth-initiated adjustments

Note: Nursing home and hospital providers may not return an overpayment with a cash refund. These providers routinely receive retroactive rate adjustments, requiring ForwardHealth to reprocess previously paid claims to reflect a new rate. This is not possible after a cash refund is done.

Topic #8417

Voiding Claims

Providers may void claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a voided claim is a complete recoupment of the payment for the entire claim. Once a claim is voided, the claim can no longer be adjusted; however, the services indicated on the voided claim may be resubmitted on a new claim.

Responses

Topic #540

An Overview of the Remittance Advice

The RA (Remittance Advice) provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. ForwardHealth provides electronic RAs to providers on their secure ForwardHealth Portal accounts when at least one claim, adjustment request, or financial transaction is processed. RAs are generated from the appropriate ForwardHealth program when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper). Generally, payment information is released and an RA is generated by ForwardHealth no sooner than the first state business day following the financial cycle.

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RA.

RAs are accessible to providers in a TXT (text) format via the secure Provider area of the Portal. Providers are also able to download the RA from their secure provider Portal account in a CSV (comma-separated values) format.

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments will receive an RA for each enrollment with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all enrolled in Wisconsin Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA (Remittance Advice) appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total for each section by adding the net amounts for all claims listed in that section. Cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

Note: Some cutbacks that are reported in detail lines will appear as EOB (Explanation of Benefits) codes and will not display an exact dollar amount.

Topic #534

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN (internal

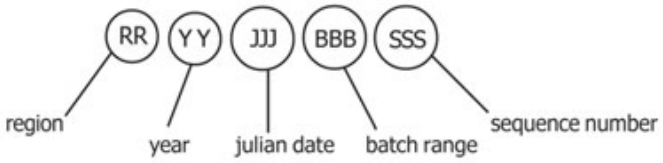
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

The ICN consists of 13 digits that identify valuable information (for example, the date the claim was received by ForwardHealth, how the claim was submitted) about the claim or adjustment request.

Interpreting Claim Numbers

Each claim and adjustment received by ForwardHealth is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 67 — Cash Payment Applied 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

Claim Status

ForwardHealth generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a claim or adjustment request using the AVR (Automated Voice Response) system or the 276/277 (276/277 Health Care Claim Status Request and Response) transaction.

If a claim or adjustment request does not appear in claim status within 45 days of the date of submission, a copy of the original claim or adjustment request should be resubmitted through normal processing channels.

Topic #10017

Creating Private Duty Nursing Claims Reports

The PDN—PAC (Private Duty Nursing—Prior Authorization Claims) report is available to PDN (private duty nursing) providers. Providers with ForwardHealth Portal accounts can create the report. Access to the PDN—PAC report is located on the Claims page of the secure provider Portal account. PDN providers with ForwardHealth Portal accounts may create the PDN—PAC report at their convenience.

Provider Services will not print and mail PDN—PAC reports to providers. The PDN—PAC report must be obtained from a secure provider Portal account.

The report is linked to a specific PDN PA number. The PDN—PAC report displays the following claim information:

- Name of the provider billing PDN service
- Procedure code and modifiers billed
- DOS (date of service)
- Units billed
- Units allowed

Each PDN—PAC report is linked to a specific PDN PA number. In order to create the report, providers must include the following information in the search criteria:

- PDN PA (prior authorizatation) number
- Member's name
- Member's ForwardHealth member identification number
- Member's date of birth
- DOS for PDN

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copays, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

Providers should note that cutback amounts indicated in the header of an adjusted or paid claim section apply only to the header. Not all cutback fields that apply to a detail line (such as copays or spenddowns) will be indicated on the RA (Remittance Advice); the detail line EOB (Explanation of Benefits) codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 (835 Health Care Claim Payment/Advice) transactions will be able to see all deducted amounts on paid and adjusted claims.

Topic #537

Electronic Remittance Information

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RAs (Remittance Advices). Electronic RAs on the Portal are not available to the following providers because these providers are not allowed to establish Portal accounts by their Provider Agreements:

- In-state emergency providers
- Out-of-state providers
- Out-of-country providers

RAs are accessible to providers in a TXT (text) format or from a CSV (comma-separated values) file via the secure Provider area of the Portal.

Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the "View Remittance Advices" menu. RAs from the last 121 days are available in the TXT format. When a user clicks on an RA, a pop-up window displays asking if the user would like to "Open" or "Save" the file. If "Open" is chosen, the document opens based on the user's application associated with opening text documents. If "Save" is chosen, the "Save As" window will open. The user can then browse to a location on their computer or network to save the document.

Users should be aware that "Word Wrap" must be turned off in the Notepad application. If it is not, it will cause distorted formatting. Also, users may need to resize the Notepad window to view all of the data. Providers wanting to print their files must ensure that the "Page Setup" application is set to the "Landscape" setting; otherwise, the printed document will not contain all the information.

Comma-Separated Values Downloadable File

A CSV file is a file format accepted by a wide range of computer software programs. Downloadable CSV-formatted RAs allow users the benefits of building a customized RA specific to their use and saving the file to their computer. The CSV file on a provider's Portal appears as linear text separated by commas until it is downloaded into a compatible software program. Once downloaded, the file may be saved to a user's computer and the data manipulated, as desired.

To access the CSV file, providers should select the "View Remittance Advices" menu at the top of the provider's Portal home page.

The CSV files are generated per financial payer and listed by RA number and RA date. A separate CSV file is listed for the last 10 RAs. Providers can select specific sections of the RA by date to download, making the information easy to read and organize.

The CSV file may be downloaded into a Microsoft Office Excel spreadsheet or into another compatible software program, such as Microsoft Office Access or OpenOffice. OpenOffice is a free software program obtainable from the internet. Google Docs and ZDNet also offer free spreadsheet applications. Microsoft Office Excel, a widely used program, is a spreadsheet application for Microsoft Windows and Mac OS. The 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended for maximum file capabilities when downloading the CSV file. Earlier versions of Microsoft Office Excel will work with the CSV file; however, files exceeding 65,000 lines may need to be split into smaller files when downloading using earlier versions. Microsoft Office Access can manage larger data files.

Refer to the CSV User Guide on the User Guides page of the Portal for instructions about Microsoft Office Excel functions that can be used to manipulate RA data downloaded from the CSV file.

835

Electronic remittance information may be obtained using the 835 (835 Health Care Claim Payment/Advice) transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim; claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a real-time compound or noncompound claim will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims and claim reversals and to download the 835 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #4822

Explanation of Benefit Codes in the Claim Header and in the Detail Lines

EOB (Explanation of Benefits) codes are four-digit numeric codes specific to ForwardHealth that correspond to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail.

The claim processing sections of the RA (Remittance Advice) report EOBs for the claim header information and detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS (date of service) that the claim covers or the total amount paid for the claim. Detail lines report information from the claim details, such as specific procedure codes or revenue codes, the amount billed for each code, and the amount paid for a detail line item.

Header EOBs are listed below the claim header information and pertain only to the header information. Detail line EOBs are listed after each detail line and pertain only to the detail line.

TEXT File

EOB codes and descriptions are listed in the RA information in the TXT (text) file.

CSV File

EOB codes are listed in the RA information from the CSV (comma-separated values) file; however, the printed messages corresponding to the codes do not appear in the file. The EOB Code Listing matching standard EOB codes to explanation text is available on the Portal for reference.

Topic #13437

ForwardHealth-Initiated Claim Adjustments

There are times when ForwardHealth must initiate a claim adjustment to address claim issues that do not require provider action and do not affect reimbursement.

Claims that are subject to this type of ForwardHealth-initiated claim adjustment will have EOB (Explanation of Benefits) code 8234 noted on the RA (Remittance Advice).

The adjusted claim will be assigned a new claim number, known as an ICN (internal control number). The new ICN will begin with "58." If the provider adjusts this claim in the future, the new ICN will be required when resubmitting the claim.

Topic #4820

Identifying the Claims Reported on the Remittance Advice

The RA (Remittance Advice) reports the first 12 characters of the MRN (medical record number) and/or a PCN (patient control number), also referred to as Patient Account Number, submitted on the original claims. The MRN and PCN fields are located beneath the member's name on any section of the RA that reports claims processing information.

Providers are strongly encouraged to enter these numbers on claims. Entering the MRN and/or the PCN on claims may assist providers in identifying the claims reported on the RA.

Note: Claims processing sections for dental and drug claims do not include the MRN or the PCN.

Topic #11537

National Correct Coding Initiative

As part of the federal PPACA (Patient Protection and Affordable Care Act) of 2010, the federal CMS (Centers for Medicare and Medicaid Services) are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI (National Correct Coding Initiative) is the CMS response to this requirement. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all professional claims and outpatient hospital claims submitted with CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits
- Procedure-to-procedure detail edits

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by Change Healthcare ClaimsXten and in ForwardHealth interChange.

Medically Unlikely Detail Edits

MUE, or units-of-service detail edits, define the maximum units of service that a provider would report under most circumstances for a single member on a single DOS (date of service) for each CPT or HCPCS procedure code. If a detail on a claim is denied for MUE, providers will receive an EOB (Explanation of Benefits) code on the RA (Remittance Advice) indicating that the detail

was denied due to NCCI.

An example of an MUE would be if procedure code 11102 (tangential biopsy of skin [eg, shave, scoop, saucerize, curette]; single lesion) was billed by a provider on a professional claim with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

Procedure-to-procedure detail edits define pairs of CPT or HCPCS codes that should not be reported together on the same DOS for a variety of reasons. This edit applies across details on a single claim or across different claims. For example, an earlier claim that was paid may be denied and recouped if a more complete code is billed for the same DOS on a separate claim. If a detail on a claim is denied for procedure-to-procedure edit, providers will receive an EOB code on the RA indicating that the detail was denied due to NCCI.

An example of a procedure-to-procedure edit would be if procedure codes 11451 (excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair) and 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the CMS Medicaid website for downloadable code lists.

Claim Details Denied as a Result of National Correct Coding Initiative Edits

Providers should take the following steps if they are uncertain why particular services on a claim were denied:

- Review ForwardHealth remittance information for the EOB message related to the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications, including the Online Handbook, to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If reimbursement for a claim or a detail on a claim is denied due to an MUE or procedure-to-procedure edit, providers may appeal the denial. Following are instructions for submitting an appeal:

- Complete the Adjustment/Reconsideration Request (F-13046 (02/2025)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs (Remittance Advices). The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. A separate Portal

account is required for each financial payer.

Providers who do not have a ForwardHealth provider Portal account may request one.

RAs are accessible to providers in a TXT (text) format via the secure provider Portal account. The TXT format file is generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. RAs from the last 121 days are available in the TXT format.

Providers can also access RAs in a CSV (comma-separated values) format from their secure provider Portal account. The CSV files are generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. A separate CSV file is listed for the last 10 RAs.

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA (Remittance Advice) include information submitted on claims and the status of the claims. The claim status designations are paid, adjusted, or denied. The RA also supplies information about why the claim was adjusted or denied or how the reimbursement was calculated for the payment.

The claims processing information in the RA is grouped by the type of claim and the status of the claim. Providers receive claims processing sections that correspond to the types of claims that have been finalized during the current financial cycle.

The claims processing sections reflect the types of claims submitted, such as the following:

- Compound drug claims
- Dental claims
- Noncompound drug claims
- Inpatient claims
- Long term care claims
- Medicare crossover institutional claims
- Medicare crossover professional claims
- Outpatient claims
- Professional claims

The claims processing sections are divided into the following status designations:

- Adjusted claims
- Denied claims
- Paid claims

Claim Types	Provider Types
Dental claims	Dentists, dental therapists, dental hygienists, HealthCheck agencies that provide dental services
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers
Long term care claims	Nursing homes
Medicare crossover institutional claims	Most providers who submit claims on the UB-04

Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form ((02/12))
Noncompound and compound drug claims	Pharmacies and dispensing physicians
Outpatient claims	Outpatient hospital providers and hospice providers
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck Other Services providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, pharmacists, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups

Topic #4821

Prior Authorization Number on the Remittance Advice

The RA (Remittance Advice) reports PA (prior authorization) numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

In the TXT (text) file, the Address page displays the provider name and "Pay to" address of the provider.

Banner Messages

The Banner Messages section of the RA (Remittance Advice) contains important, time-sensitive messages for providers. For example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages; therefore, providers who receive multiple RAs should read all of their banner messages.

Banner messages appear on the TXT file but not on the CSV (comma-separated values) file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB (Explanation of Benefits) code descriptions are listed in the RA information in the TXT file.

EOB codes are listed in the RA information from the CSV file; however, the printed messages corresponding to the codes do not appear in the file.

Financial Transactions Page

The Financial Transactions section details the provider's weekly financial activity. Financial transactions reported on the RA include payouts, refunds, accounts receivable, and payments for claims.

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (that is, nursing home assessment reimbursement).

Refunds are payments made to providers for overpayments.

The Accounts Receivable section displays the accounts receivable for amounts owed by providers. The accounts receivable is set to automatically recover any outstanding balance so that money owed is automatically recouped from the provider. If the full amount cannot be recouped during the current financial cycle, an outstanding balance will appear in the "Balance" column.

In the Accounts Receivable section, the "Amount Recouped In Current Cycle" column, when applicable, shows the recoupment amount for the financial cycle as a separate number from the "Recoupment Amount To Date." The "Recoupment Amount To Date" column shows the total amount recouped for each accounts receivable, **including** the amount recouped in the current cycle. The "Total Recoupment" **line** shows the sum of all recoupments to date in the "Recoupment Amount To Date" column and the sum of all recoupments for the current financial cycle in the "Amount Recouped In Current Cycle" column.

For decreasing claim adjustments listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. Providers will see net difference between the claim and the adjustment reflected on the RA.

Each new claim adjustment is assigned an identification number called the "Adjustment ICN (internal control number)." For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction—The first character indicates the type of financial transaction that created the accounts receivable.	V—Capitation adjustment 1—OBRA Level 1 screening void request 2—OBRA Nurse Aide Training/Testing void request
Identifier—10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

The Service Code Descriptions section lists all the service codes (that is, procedure codes or revenue codes) reported on the RA with their corresponding descriptions.

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA (Omnibus Budget Reconciliation Act of 1987) Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA (Remittance Advice) if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

To adjust a claim, ForwardHealth recoups the **difference**—or pays the **difference**—between the original claim amount and the claim adjustment amount. This difference will be reflected on the RA.

In the Claim Adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the claim adjustment appears directly below the original claim header information. Providers should check the Adjustment EOB (Explanation of Benefits) code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

The Claim Adjustments section only lists detail lines for a claim adjustment if that claim adjustment has detail line EOBs. This section does not list detail lines for the original paid claim.

Note: For adjusted compound and noncompound claims, only the compound drug sections include detail lines.

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: Additional Payment, Overpayment To Be Withheld, or Refund Amount Applied. The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

If the difference is a positive dollar amount, indicating that ForwardHealth owes additional monies to the provider, then the amount appears in the Additional Payment line.

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the Overpayment To Be Withheld line. ForwardHealth automatically withholds this amount from payments made to the provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under Accounts Receivable.

An amount appears for Refund Amount Applied if ForwardHealth makes a payment to refund a cash receipt to a provider.

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA (Remittance Advice) if any of their claims were denied during the current financial cycle.

In the denied claims section, providers will see the original claim header information reported along with EOB (Explanation of Benefits) codes for the claim header and the detail lines, as applicable. Providers should refer to the EOB Code Description section of the RA to determine why the claim was denied.

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

```
REPORT:   CRA-HCDN-R                                        FORWARDHEALTH INTERCHANGE                                   DATE:  MM/DD/CCYY
   RA#:   999999999                                       <Financial Cycle Description>                                 PAGE:       9,999
 PAYER:   XXXX                                              PROVIDER REMITTANCE ADVICE
                                                        PROFESSIONAL SERVICE CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                    PAYMENT DATE       MM/DD/CCYY

  --ICN--         PCN           MRN        SERVICE DATES    BILLED          OTH INS         SPENDDOWN
                                            FROM   TO       AMOUNT          AMOUNT          AMOUNT

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY  999,999,999.99   9,999,999.99    999,999.99


HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


                                 SERVICE DATES                            PA NUMBER
PROC CD  MODIFIERS   ALLW UNITS  FROM    TO      RENDERING PROVIDER      BILLED AMT     DETAIL EOBS
 XXXXX   XX XX XX XX    9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX    XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX    9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX    XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX    9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX    XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX    9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX    XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999



            TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

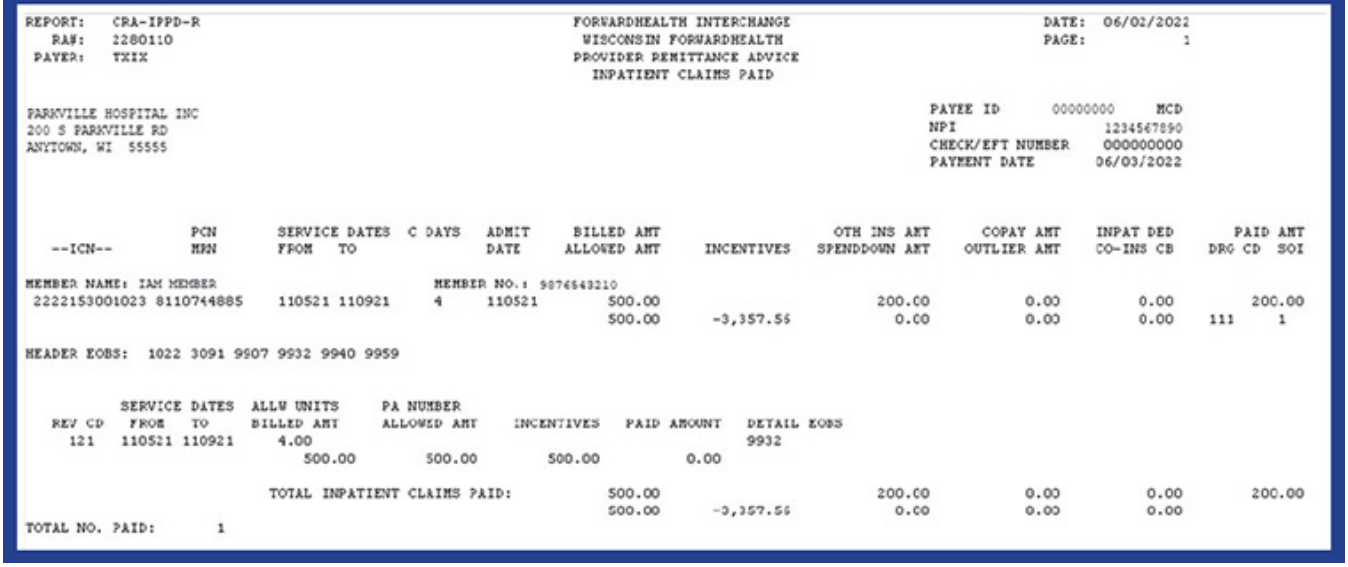
Topic #4825

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA (Remittance Advice) if any of their claims were determined payable during the current financial cycle.

In a paid claims section, providers will see the original claim information reported along with EOB (Explanation of Benefits) codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined. The Incentives column is calculated in accordance with the 835 (835 Health Care Claim Payment/Advice) standards to balance among the service line, the claim, and the transaction.

Sample Inpatient Claims Paid Section of the Remittance Advice



REPORT: CRA-IPPD-R
RA#: 2280110
PAYER: TXIX

FORWARDHEALTH INTERCHANGE
WISCONSIN FORWARDHEALTH
PROVIDER REMITTANCE ADVICE
INPATIENT CLAIMS PAID

DATE: 06/02/2022
PAGE: 1

PARKVILLE HOSPITAL INC
200 S PARKVILLE RD
ANYTOWN, WI 55555

PAYEE ID 00000000 MCD
NPI 1234567890
CHECK/EFT NUMBER 000000000
PAYMENT DATE 06/03/2022

--ICN--	PCN MRN	SERVICE DATES FROM TO	C DAYS	ADMIT DATE	BILLED AMT ALLOWED AMT	INCENTIVES	OTH INS AMT SPENDDOWN AMT	COPAY AMT OUTLIER AMT	INPAT DED CO-INS CB	PAID AMT DRG CD SOI
MEMBER NAME: IAM MEMBER				MEMBER NO.: 9876543210						
2222153001023	8110744885	110521 110921	4	110521	500.00		200.00	0.00	0.00	200.00
					500.00	-3,357.56	0.00	0.00	0.00	111 1

HEADER EOBS: 1022 3091 9907 9932 9940 9959

REV CD	SERVICE DATES FROM TO	ALLW UNITS BILLED AMT	PA NUMBER ALLOWED AMT	INCENTIVES	PAID AMOUNT	DETAIL EOBS
121	110521 110921	4.00				9932
		500.00	500.00	500.00	0.00	

TOTAL INPATIENT CLAIMS PAID:	500.00	200.00	0.00	200.00
	500.00	0.00	0.00	

TOTAL NO. PAID: 1

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider ForwardHealth Portal accounts from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

RAs (Remittance Advices) are generated and posted to secure provider Portal accounts from one or more of the following ForwardHealth financial payers:

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs)
- HDAP (Wisconsin HIV Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

Note: Each of the four payers generate separate RAs for the claims, adjustment requests, or other financial transactions submitted to the payer. A provider who submits claims, adjustment requests, or other financial transactions to more than one of these payers may receive several RAs.

The RA is generated per provider enrollment. Providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, but the same NPI will be reported on each of the RAs.

For instance, a hospital has obtained a single NPI. The hospital has a clinic, a lab, and a pharmacy that are all enrolled with ForwardHealth. The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Topic #6237

Reporting a Lost Check

To report a lost check to ForwardHealth, providers are required to mail or fax a letter to ForwardHealth Financial Services. Providers are required to include the following information in the letter:

- Provider's name and address, including the ZIP+4 code
- Provider's identification number
  - For healthcare providers, include the NPI (National Provider Identifier) and taxonomy code.
  - For non-healthcare providers, include the provider identification number.
- Check number, check date, and check amount (This should be recorded on the RA (Remittance Advice).)
- A written request to stop payment and reissue the check
- The signature of an authorized financial representative (An individual provider is considered his or her own authorized financial representative.)

Fax the letter to ForwardHealth at 608-221-4567 or mail it to the following address:

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

All claims, including compound, noncompound, and dental claims, are available for viewing on the ForwardHealth Portal.

To search and view claims on the Portal, providers may do the following:

- Go to the Portal.
- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page, or the provider may select claim search and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Topic #4829

Sections of the Remittance Advice

The RA (Remittance Advice) information in the TXT (text) file includes the following sections:

- Address page
- Banner messages
- Paper check information, if applicable
- Claims processing information
- EOB (Explanation of Benefits) code descriptions
- Financial transactions
- Service code descriptions
- Summary
- Claim sequence numbers

The RA information in the CSV (comma-separated values) file includes the following sections:

- Payment
- Payment hold
- Service codes and descriptions
- Financial transactions
- Summary
- Inpatient claims
- Outpatient claims
- Professional claims
- Medicare crossovers—Professional
- Medicare crossovers—Institutional
- Compound drug claims
- Noncompound drug claims
- Dental claims
- Long term care claims
- Financial transactions
- Summary
- Claim sequence numbers

Providers can select specific sections of the RA in the CSV file within each RA date to be downloaded making the information easy to read and to organize.

Remittance Advice Header Information

The first page of each section of the RA (except the address page of the TXT file) displays the same RA header information.

The following fields are on the left-hand side of the header:

- The technical name of the RA section (for example, CRA-TRAN-R), which is an internal ForwardHealth designation
- The RA number, which is a unique number assigned to each RA that is generated
- The name of the payer (Medicaid, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program))
- The Pay To address of the provider. The Pay To address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle
- The name of the RA section (for example, Financial Transactions or Professional Services Claims Paid)

The right-hand side of the header reports the following information:

- The date of the financial cycle and date the RA was generated
- The page number
- The Payee ID of the provider. A payee ID is defined as the identification number of a unique entity receiving payment for goods and/or services from ForwardHealth. The payee ID is up to 15 characters long and may be based on a pre-existing identification number, such as the Medicaid provider number. The payee ID is an internal ForwardHealth designation. The Medicaid provider number will display in this field for providers who do not have an NPI (National Provider Identifier).
- The NPI of the provider, if applicable. This field will be blank for those providers who do not have an NPI.
- The number of the check issued for the RA, if applicable
- The date of payment on the check, if applicable

Topic #544

Verifying Accuracy of Claims Processing

After obtaining ForwardHealth remittance information, providers should compare it to the claims or adjustment requests to verify that ForwardHealth processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should do the following:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a member's account, providers should note the date on the ForwardHealth remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

Responsibilities

Topic #516

Accuracy of Claims

The provider is responsible for the accuracy and completeness of all claims submitted either by the provider or by an outside billing service or clearinghouse.

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests be valid, including:

- Diagnosis codes
- Revenue codes
- HCPCS (Healthcare Common Procedure Coding System) codes
- HIPPS (Health Insurance Prospective Payment System) codes
- CPT (Current Procedural Terminology) codes

Providers should refer to current national coding and billing manuals for information on valid code sets. ForwardHealth will:

- Deny claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes.
- Return PA requests received without valid codes to the provider.

Providers may submit claims only **after** the service is provided.

A provider may not seek reimbursement from ForwardHealth or a state-contracted HMO for a noncovered service by charging ForwardHealth for a covered service that was not actually provided to the member and then applying the reimbursement toward the noncovered service. In addition, a provider may not seek reimbursement for two separate covered services to receive additional reimbursement over the maximum allowed amount for the one service that was provided. Such actions are considered fraudulent.

Topic #1073

Billing Private Duty Nursing Across Midnight

Providers are required to bill for each DOS (date of service) that care was provided. If a nurse provides care for a member across midnight, the nurse is required to split the billing over two DOS since the shift extends over two dates. This means that two modifiers must be used, one for the hours of the shift occurring before midnight, and another to designate the hours of the shift occurring after midnight on the next calendar day.

For example, if a nurse begins care for a member at 8 p.m. on December 1 and ends care at 4 a.m. on December 2, the nurse should bill for four hours of care on December 1 with modifier UH and four hours of care on December 2 with modifier UJ.

Providers billing for PDN (private duty nursing) hours during shifts spanning midnight must apply the PDN billing conversion guidelines to each DOS as shown in the following tables.

Day	Start of Shift	Time	Minutes	Billable Units
1	UH	10 p.m. to Midnight	120	2
2	UJ	Midnight to 10 a.m.	600	10

Day	Start of Shift	Time	Minutes	Billable Units
1	UH	10:15 p.m. to Midnight	105	1.7
2	UJ	Midnight to 10:15 a.m.	615	10.2

Topic #10039

Billing for More Than One Shift Worked in a Day

A provider providing PDN (private duty nursing) services to the same member for more than one shift in a day should combine the number of minutes for the shifts on the DOS (date of service) before converting to billable units. Combining the minutes from the shifts worked in the day before converting to billable units may be to the provider's advantage, as shown in the example below.

Shift	Start of Shift Modifier	Time	Minutes	Billable Units
1	UJ	Midnight to 6:15 a.m.	375	6.2
2	UH	6:15 p.m. to Midnight	345	5.7
Billable units if shift minutes are converted separately				11.9
Sum of minutes worked in the day			720	
Billable units if the day's minutes are summed before converting to units				12

In some instances, combining the minutes from the shifts worked in the day before converting to billable units may not result in a difference, as shown in the example below.

Shift	Start of Shift Modifier	Time	Minutes	Billable Units
1	UJ	Midnight to 7:00 a.m.	420	7
2	UH	7:00 p.m. to Midnight	300	5
Billable units if shift minutes are converted separately				12
Sum of minutes worked in the day			720	
Billable units if the day's minutes are summed before converting to units				12

Topic #10038

Billing for Shifts Spanning Two Prior Authorized 13-Week Segments

PDN (private duty nursing) services that were provided on consecutive days spanning two different PA (prior authorization) 13-week segments cannot be billed on the same claim detail. Only DOS (dates of service) contained in the PA 13-week segment may be included in the claim detail.

Topic #10037

Claim Denials Due to Exceeding Authorized Amounts

Providers are cautioned to bill units of service carefully. Incorrect billing could result in the denial of claims billed within the authorization period if more time is billed for PDN (private duty nursing) services than the amount of time that is authorized for PDN. When the source of the billing error is determined, providers should submit claim adjustments.

Topic #366

Copay Amounts

Copay amounts collected from members should not be deducted from the charges submitted on claims. Providers should indicate their usual and customary charges for all services provided.

In addition, copay amounts should not be included when indicating the amount paid by other health insurance sources.

The appropriate copay amount is automatically deducted from allowed payments. Remittance information reflects the automatic deduction of applicable copay amounts.

Topic #22798

Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

- Allows the OIG (Office of the Inspector General) to review claims prior to payment.
- Requires providers to submit all required documentation to support approval and payment of PIR-selected claims.

The goal of the PIR program is to further safeguard the integrity of Wisconsin DHS (Department of Health Services)-administered public assistance programs, such as BadgerCare Plus and Wisconsin Medicaid, from fraud, waste, and abuse by:

- Proactively reviewing claims prior to payment to ensure federal and state requirements are met.
- Providing enhanced, compliance-based technical assistance to meet the specific needs of providers.
- Increasing the monitoring of benefit and service areas that are at high risk for fraud, waste, and abuse.

Fraud, waste, and abuse includes the potential overutilization of services or other practices that directly or indirectly result in unnecessary program costs, such as:

- Billing for items or services that were not rendered.
- Incorrect or excessive billing of CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes.
- Unit errors, duplicate charges, and redundant charges.
- Billing for services outside of the provider specialty.
- Insufficient documentation in the medical record to support the charges billed.
- Lack of medical necessity or noncovered services.

Note: Review of claims in the PIR process does not preclude claims from future post-payment audits or review.

Payment Integrity Review Program Overview

When a provider submits a claim electronically via the ForwardHealth Portal, the system will display a message if the claim is subject to PIR. The message will instruct providers to submit supporting documentation with the claim. Providers have seven days to attach documentation to claims. The claim will automatically be denied if documentation is not attached within seven days.

Claims that meet PIR requirements may be eligible for payment once they are accurate and complete. Claims that do not meet PIR requirements may be denied or repriced. In these cases, providers are encouraged to:

- Review the EOB (Explanation of Benefits) for billing errors.
- Refer to the Online Handbook for claims documentation and program policy requirements.
- Correct the PIR billing errors and resubmit the claim.

Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review
- Pre-Payment Review
- Intermediate Sanctions

For each type of review, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

	Claims Review	Pre-Payment Review	Intermediate Sanction
How claims are selected for review	A sampling of claims is selected from providers, provider types, benefit areas, or service codes identified by the OIG.	The OIG has reasonable suspicion that a provider is violating program rules.	The OIG has established cause that a provider is violating program rules.
How providers are notified that selected claims are under review	The provider receives a message on the Portal.	The provider receives a Provider Notification letter and message on the Portal.	The provider receives a Notice of Intermediate Sanction letter and message on the Portal.
How to successfully exit the review	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	75% of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the three-month period may not drop more than 10% of the provider's volume of submitted claims prior to pre-payment review.	The provider must meet parameters set during the sanction process.

Claims Review

In accordance with Wis. Admin. Code § DHS 107.02(2), the OIG may identify providers, provider types, benefit areas, or procedure codes, and based on those criteria, choose a sampling of claims to review prior to payment. When a claim submitted through the Portal that meets one of these criteria is selected for review, a message will appear on the Portal to notify the provider that the claim must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

Pre-Payment Review

In accordance with Wis. Admin Code § DHS 106.11, if the OIG has cause to suspect that a provider is prescribing or providing services that are not necessary for members, are in excess of the medical needs of members, or do not conform to applicable professional practice standards, the provider's claims may be subject to review prior to payment. Providers who are subject to this type of review will receive a Pre-Payment Review Initial Notice letter, explaining that the OIG has identified billing practice or program integrity concerns in the provider's claims that warrant the review. This notice details the steps the provider must follow to substantiate their claims and the length of time their claims will be subject to review. Additionally, a message will appear on the Portal when the provider submits claims to notify the provider that certain claims must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from pre-payment review, both of the following conditions must be met:

- 75% of the provider's reviewed claims over a three-month period are approved to be paid.
- The number of claims the provider submits during that three-month period may not drop more than 10% from their submitted claim amount prior to pre-payment review.

The OIG reserves the right to adjust these thresholds according to the facts of the case.

Intermediate Sanction Review

In accordance with Wis. Admin. Code § DHS 106.08(3)(d), if the OIG has established cause that a provider is violating program rules, the OIG may impose an intermediate sanction that requires the provider's claims to be reviewed prior to payment. Providers who are subject to this type of review will be sent an official Intermediate Sanction Notice letter from the OIG that details the program integrity concerns that warrant the sanction, the length of time the sanction will apply, and the provider's right to appeal the sanction. The provider also will receive a message on the Portal when submitting claims that indicates certain claims must be submitted with the necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from an intermediate sanction, the provider must meet the parameters set during the sanction process.

Topic #10057

Private Duty Nursing Claims Denied

Reimbursement for PDN (private duty nursing) services is limited to 1,440 minutes (for example, 240 six-minute increments) per member, per calendar day. Reimbursement limits are adjusted to accommodate changes in the length of the calendar day resulting from the beginning and ending of daylight savings time. Reimbursement for each nurse is limited to 12 hours per calendar day and 60 hours per calendar week. Claims for PDN that exceed the number of hours authorized for the 13-week segment of the authorization period will not be reimbursed.

Topic #547

Submission Deadline

ForwardHealth recommends that providers submit claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

With few exceptions, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims. Members are not responsible for resolving claims. To resolve claims before the submission deadline, ForwardHealth encourages providers to use all available resources.

Claims

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS (date of service). This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copay, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Exceptions to the Submission Deadline

State and federal laws provide eight exceptions to the submission deadline. According to federal regulations and Wis. Admin. Code DHS 106.03, ForwardHealth may consider exceptions to the submission deadline only in the following circumstances:

- Change in a nursing home resident's LOC (level of care) or liability amount
- Decision made by a court order, fair hearing, or the Wisconsin DHS (Department of Health Services)
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment
- Reconsideration or recoupment
- Retroactive enrollment for persons on GR (General Relief)
- Medicare denial occurs after ForwardHealth's submission deadline
- Refund request from an other health insurance source
- Retroactive member enrollment

ForwardHealth has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing.

Topic #13937

Transitions to and from Central Standard Time

Providers billing PDN (private duty nursing) services provided on consecutive DOS (dates of service) during which CDT (Central Daylight Time) changes to CST (Central Standard Time) or CST changes to CDT are required to be billed on separate claim details as one DOS per claim detail. Private duty nursing services provided on consecutive days spanning the transition from CDT to CST or from CST to CDT cannot be billed on the same claim detail as a range of dates.

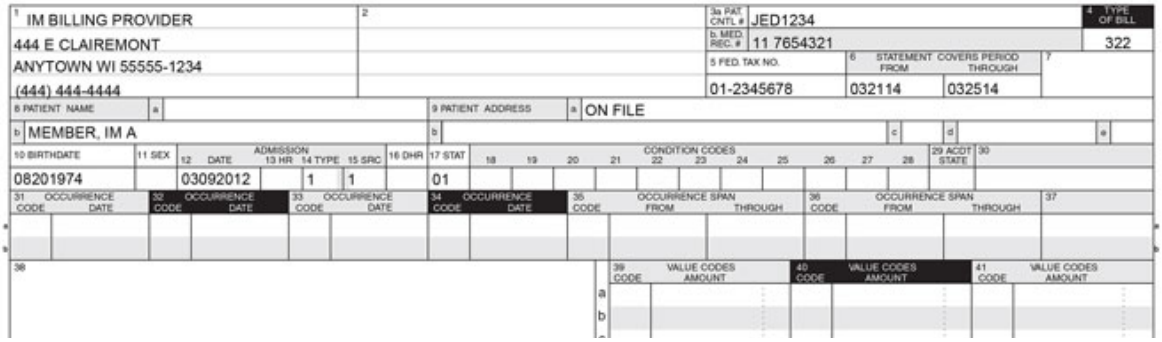
Typically it is less complicated to prepare claims using separate claim details for each DOS than it is to prepare claims using range dates.

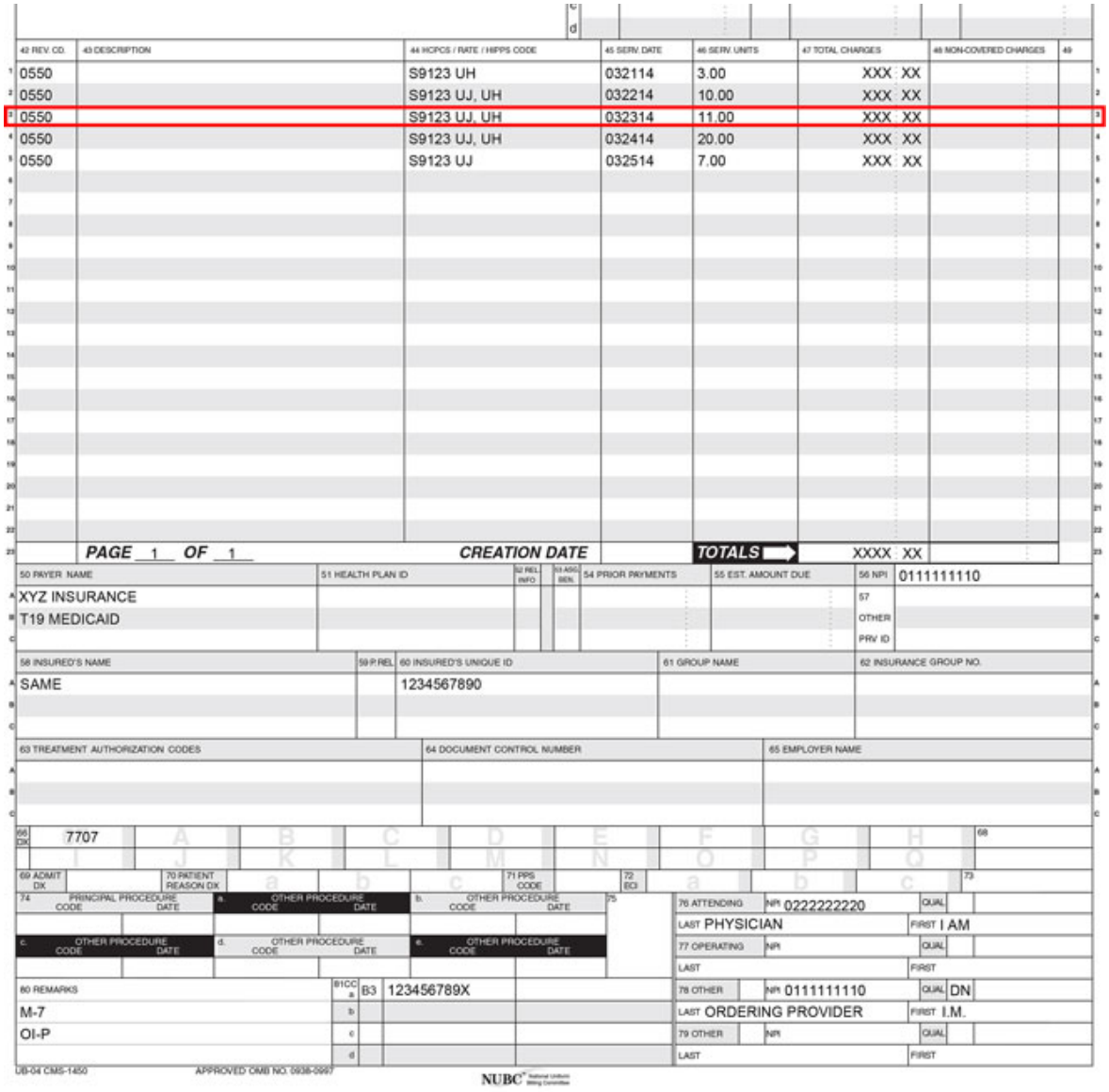
The claim example below illustrates a claim for the following situation:

- Private duty nursing services were provided every day for six consecutive days.
- Some of the PDN services were provided on a day of transition from CDT to CST (the clock was set back an hour).
- The provider is claiming for five shifts of 10 hours per shift except for 11 hours on the time change date.
- Each shift began at 9 p.m. and ended at 7 a.m.

Sample UB-04 Claim Form for Private Duty Nursing Services Including Shifts Spanning Daylight Changes

The date in the detail line circled below indicates a change from Central Daylight Time to Central Standard Time.





42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0550		S9123 UH	032114	3.00	XXX XX		
0550		S9123 UJ, UH	032214	10.00	XXX XX		
0550		S9123 UJ, UH	032314	11.00	XXX XX		
0550		S9123 UJ, UH	032414	20.00	XXX XX		
0550		S9123 UJ	032514	7.00	XXX XX		
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXXX XX		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0111111110
XYZ INSURANCE						57	
T19 MEDICAID						OTHER PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SAME		1234567890		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX: 7707 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI 0222222220	QUAL	
LAST PHYSICIAN		FIRST I AM	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI 0111111110	QUAL DN	
LAST ORDERING PROVIDER		FIRST I.M.	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC a	B3	123456789X
M-7	b		
OI-P	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

In this situation the "personal work log" used as the basis for the completed claim form example may look like the example below.

Week Day and Dates of Service —	Start Time	End Time	Start of Shift Modifier	Start Time	End Time	Start of Shift Modifier	Hours Worked	Week
Friday, 11/04/11				2100	0000	UH	3	1
Saturday, 11/05/11	0000	0700	UJ	2100	0000	UH	10	
Sunday, 11/06/11	0000	0700	UJ	2100	0000	UH	11	2
Monday, 11/07/11	0000	0700	UJ	2100	0000	UH	10	
Tuesday, 11/08/11	0000	0700	UJ	2100	0000	UH	10	
Wednesday, 11/09/11	0000	0700	UJ				7	
						Sum	51	

Topic #517

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

Providers may not discriminate against BadgerCare Plus or Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient.

For services requiring a member copay, providers should still indicate their usual and customary charge. The copay amount collected from the member should not be deducted from the charge submitted. When applicable, ForwardHealth automatically deducts the copay amount.

For most services, ForwardHealth reimburses the lesser of the provider's usual and customary charge, plus a professional dispensing fee, if applicable, or the maximum allowable fee established.

Submission

Topic #542

Attached Documentation

Providers should not submit additional documentation with a claim **unless** specifically requested.

Topic #2169

Billing Prior Authorized Services With Non-Prior Authorized Services

Claims for services provided under a PA (prior authorization) number may be submitted on the same claim as claims for services not requiring PA. However, an exception applies if a service with the same procedure code is provided outside the grant and expiration dates on the PA and then again between the grant and expiration dates on the PA. These services cannot be submitted on a single claim form or the claim will be denied. Two separate claims must be submitted for services in this situation; one for services provided outside the grant and expiration dates and one for services provided between these dates.

For example, a home health PT (physical therapy) visit (procedure code 97799) that counts toward the 30-visit threshold for the calendar year is made to a member on February 3, 2005, and, therefore, does not require PA. Beginning on February 7, 2005, the member has an approved PA to receive home health PT (procedure code 97799) because all of the 30 threshold visits for the calendar year have been used. When the physical therapist makes a visit to provide services on February 10, 2005, the service must be billed on a separate claim form from the February 3, 2005, visit because the February 3, 2005, visit falls outside the PA grant and expiration dates for that procedure code. Billing the two visits on the same claim form would cause the claim to be denied.

Topic #15737

Claims for Services Prescribed, Referred, or Ordered

Claims for services that are prescribed, referred, or ordered must include the Type 1 NPI (National Provider Identifier) of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. ForwardHealth will deny claims if they do not include a Medicaid-enrolled provider's NPI or if they are submitted with the NPI of a provider who is not enrolled with Wisconsin Medicaid. (However, providers should **not** include the NPI of a provider who prescribes, refers, or orders services on claims for services that are not prescribed, referred, or ordered, as those claims will also deny if the provider is not enrolled in Medicaid.)

Note: Claims submitted for ESRD (end-stage renal disease) services do not require **referring** provider information; however, **prescribing** and **ordering** provider information will still be required on claims.

Contacting Prescribing/Referring/Ordering Provider After a Claim Denial

If a claim is denied for prescribed, referred, or ordered services because the prescribing/referring/ordering provider was not Medicaid-enrolled, the rendering provider should contact the prescribing/referring/ordering provider and:

- Communicate that the prescribing/referring/ordering provider is must be enrolled in Wisconsin Medicaid.

- Inform the prescribing/referring/ordering provider of the limited enrollment available for prescribing/referring/ordering providers.
- Resubmit the claim once the prescribing/referring/ordering provider has enrolled in Wisconsin Medicaid.

Exception for Prescribed, Referred, or Ordered Services Prior to a Member's Medicaid Enrollment

Providers may submit claims for prescribed, referred, or ordered services by a non-Medicaid-enrolled provider if the member was not yet enrolled in Wisconsin Medicaid at the time the prescription, referral, or order was written (and the member has since enrolled in Wisconsin Medicaid). However, once the prescription, referral, or order expires, the prescribing/referring/ordering provider is required to enroll in Wisconsin Medicaid if they continue to prescribe, refer, or order services for the member.

The procedures for submitting claims for this exception depend on the type of claim submitted:

- Institutional, professional, and dental claims for this exception must be sent to the following address:

  ForwardHealth
  P.R.O. Exception Requests
  Ste 50
  313 Blettner Blvd
  Madison WI 53784

  A copy of the prescription, referral, or order must be included with the claim.

- Pharmacy and compound claims for this exception do **not** require any special handling. These claims include a prescription date, so they can be processed to bypass the prescriber Medicaid enrollment requirement in situations where the provider prescribed services before the member was enrolled in Wisconsin Medicaid.

Topic #6957

Copy Claims on the ForwardHealth Portal

Providers can copy institutional, professional, and dental paid claims on the ForwardHealth Portal. Providers can open any paid claim, click the "Copy" button, and all of the information on the claim will be copied over to a new claim form. Providers can then make any desired changes to the claim form and click "Submit" to submit as a new claim. After submission, ForwardHealth will issue a response with a new ICN (internal control number) along with the claim status.

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB (Explanation of Benefits) codes and descriptions for any claim submitted to ForwardHealth on the ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE (Direct Data Entry) on the ForwardHealth Portal:

- Professional claims
- Institutional claims
- Dental claims
- Compound drug claims
- Noncompound drug claims

DDE is an online application that allows providers to submit claims directly to ForwardHealth.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted, and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes
- Modifiers
- Diagnosis codes
- Place of service codes

On institutional claim forms, providers may search for and select the following:

- Type of bill
- Patient status
- Visit point of origin
- Visit priority
- Diagnosis codes
- Revenue codes
- Procedure codes
- HIPPS (Health Insurance Prospective Payment System) codes
- Modifiers

On dental claims, providers may search for and select the following:

- Procedure codes
- Rendering providers
- Area of the oral cavity
- Place of service codes

On compound and noncompound drug claims, providers may search for and select the following:

- Diagnosis codes
- NDCs (National Drug Codes)
- Place of service codes
- Professional service codes
- Reason for service codes

- Result of service codes

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME (durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS (Point-of-Sale) claims, are viewable via DDE.

Topic #15957

Documenting and Billing the Appropriate National Drug Code

Providers are required to use the NDC (National Drug Code) of the administered drug and not the NDC of another manufacturer's product, even if the chemical name is the same. Providers should not preprogram their billing systems to automatically default to NDCs that do not accurately reflect the product that was administered to the member.

Per Wis. Admin. Code §§ DHS (Department of Health Services) 106.03(3) and 107.10, submitting a claim with an NDC other than the NDC on the package from which the drug was dispensed is considered an unacceptable practice.

Upon retrospective review, ForwardHealth can seek recoupment for the payment of a claim from the provider if the NDC(s) submitted does not accurately reflect the product that was administered to the member.

Topic #344

Electronic Claim Submission

Providers are encouraged to submit claims electronically. Electronic claim submission does the following:

- Adapts to existing systems
- Allows flexible submission methods
- Improves cash flow
- Offers efficient and timely payments
- Reduces billing and processing errors
- Reduces clerical effort

Topic #16937

Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

Effective for claims and claim adjustments submitted electronically via the Portal or PES software on and after June 16, 2014, other insurance information must be submitted at the detail level on professional, institutional, and dental claims and adjustments if it was processed at the detail level by the primary insurance. Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services; therefore, 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 MCO (managed care organization).

Other insurance information that is submitted at the detail level via the Portal or PES software will be processed at the detail level by ForwardHealth.

Under HIPAA (Health Insurance Portability and Accountability Act of 1996), claims and adjustments submitted using an 837 transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

Adjustments to Claims Submitted Prior to June 16, 2014

Providers who submit professional, institutional, or dental claim adjustments electronically on and after June 16, 2014, for claims originally submitted prior to June 16, 2014, are required to submit other insurance information at the detail level on the adjustment if it was processed at the detail level by the primary insurance.

Topic #365

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO or SSI HMO and should be submitted to fee-for-service.

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes entered into all fields, including those fields that are Not Required or Optional.

If the information in all fields is not valid and recognized by ForwardHealth, the claim will be denied.

Provider Numbers

For health care providers, NPIs (National Provider Identifiers) are required in all provider number fields on paper claims and 837 (837 Health Care Claim) transactions, including rendering, billing, referring, prescribing, attending, and Other provider fields.

Non-healthcare providers, including personal care providers, SMV (specialized medical vehicle) providers, blood banks, and CCOs (community care organizations) should enter valid provider numbers into fields that require a provider number.

Topic #562

HMOs and Managed Care Organizations

Claims for services covered by the member's state-contracted HMO or MCO (managed care organization) should be submitted to the HMO or MCO provider services.

Topic #10837

Note Field for Most Claims Submitted Electronically

In some instances, ForwardHealth requires providers to include a description of a service identified by an unlisted, or NOC (not otherwise classified), procedure code. Providers submitting claims electronically should include a description of an NOC procedure code in a Notes field, if required. The Notes field allows providers to enter up to 80 characters. In some cases, the Notes field allows providers to submit NOC procedure code information on a claim electronically instead of on a paper claim or with a paper attachment to an electronic claim.

The Notes field should only be used for NOC procedure codes that do not require PA (prior authorization).

Claims Submitted via the ForwardHealth Portal Direct Data Entry or Provider Electronic Solutions

A notes field is available on the ForwardHealth Portal DDE (Direct Data Entry) and PES (Provider Electronic Solutions) software when providers submit the following types of claims:

- Professional
- Institutional
- Dental

On the professional form, the Notes field is available on each detail. On the institutional and dental forms, the Notes field is only available on the header.

Claims Submitted via 837 Health Care Claim Transactions

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in certain loops/segments on the 837 (837 Health Care Claim) transactions. Refer to the companion guides for more information.

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

Paper claims submitted to ForwardHealth on the 1500 Health Insurance Claim Form ((02/12)) and UB-04 Claim Form are processed using OCR (Optical Character Recognition) software that recognizes printed, alphanumeric text. OCR software increases efficiency by alleviating the need for keying in data from paper claims.

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/2017)) form and the Noncompound Drug Claim (F-13072 (02/2025)) form.

Speed and Accuracy of Claims Processing

OCR software processes claim forms by reading text within fields on claim forms. After a paper claim form is received by ForwardHealth, the claim form is scanned so that an image can be displayed electronically. The OCR software reads the electronic image on file and populates the information into the ForwardHealth interChange system. This technology increases accuracy by removing the possibility of errors being made during manual keying.

OCR software speeds paper claim processing, but only if providers prepare their claim forms correctly. In order for OCR software to read the claim form accurately, the quality of copy and the alignment of text within individual fields on the claim form

need to be precise. If data are misaligned, the claim could be processed incorrectly. If data cannot be read by the OCR software, the process will stop and the electronic image of the claim form will need to be reviewed and keyed manually. This will cause an increase in processing time.

Handwritten Claims

Submitting handwritten claims should be avoided whenever possible. ForwardHealth accepts handwritten claims; however, it is very difficult for OCR software to read a handwritten claim. If a handwritten claim cannot be read by the OCR software, it will need to be keyed manually from the electronic image of the claim form. Providers should avoid submitting claims with handwritten corrections as this can also cause OCR software processing delays.

Use Original Claim Forms

Only original 1500 Health Insurance Claim Forms and UB-04 Claim Forms should be submitted. Original claim forms are printed in red ink and may be obtained from a federal forms supplier. ForwardHealth does not provide these claim forms. Claims that are submitted as photocopies cannot be read by OCR software and will need to be keyed manually from an electronic image of the claim form. This could result in processing delays.

Use Laser or Ink Jet Printers

It is recommended that claims are printed using laser or ink jet printers rather than printers that use DOT matrix. DOT matrix printers have breaks in the letters and numbers, which may cause the OCR software to misread the claim form. Use of old or worn ink cartridges should also be avoided. If the claim form is read incorrectly by the OCR software, the claim may be denied or reimbursed incorrectly. The process may also be stopped if it is unable to read the claim form, which will cause a delay while it is manually reviewed.

Alignment

Alignment within each field on the claim form needs to be accurate. If text within a field is aligned incorrectly, the OCR software may not recognize that data are present within the field or may not read the data correctly. For example, if a reimbursement amount of $300.00 is entered into a field on the claim form, but the last "0" is not aligned within the field, the OCR software may read the number as $30.00, and the claim will be reimbursed incorrectly.

To get the best alignment on the claim form, providers should center information vertically within each field, and align all information on the same horizontal plane. Avoid squeezing two lines of text into one of the six line items on the 1500 Health Insurance Claim Form.

The following sample claim forms demonstrate correct and incorrect alignment:

- Correct alignment for the 1500 Health Insurance Claim Form.
- Incorrect alignment for the 1500 Health Insurance Claim Form.
- Correct alignment for the UB-04 Claim Form.
- Incorrect alignment for the UB-04 Claim Form.

Clarity

Clarity is very important. If information on the claim form is not clear enough to be read by the OCR software, the process may stop, prompting manual review.

The following guidelines will produce the clearest image and optimize processing time:

- Use 10-point or 12-point Times New Roman or Courier New font.
- Type all claim data in uppercase letters.

- Use only black ink to complete the claim form.
- Avoid using italics, bold, or script.
- Make sure characters do not touch.
- Make sure there are no lines from the printer cartridge anywhere on the claim form.
- Avoid using special characters such as dollar signs, decimals, dashes, asterisks, or backslashes, unless it is specified that these characters should be used.
- Use Xs in check boxes. Avoid using letters such as Y for Yes, N for No, M for Male, or F for Female.
- Do not highlight any information on the claim form. Highlighted information blackens when it is imaged, and the OCR software will be unable to read it.

Note: The above guidelines will also produce the clearest image for claims that need to be keyed manually from an electronic image.

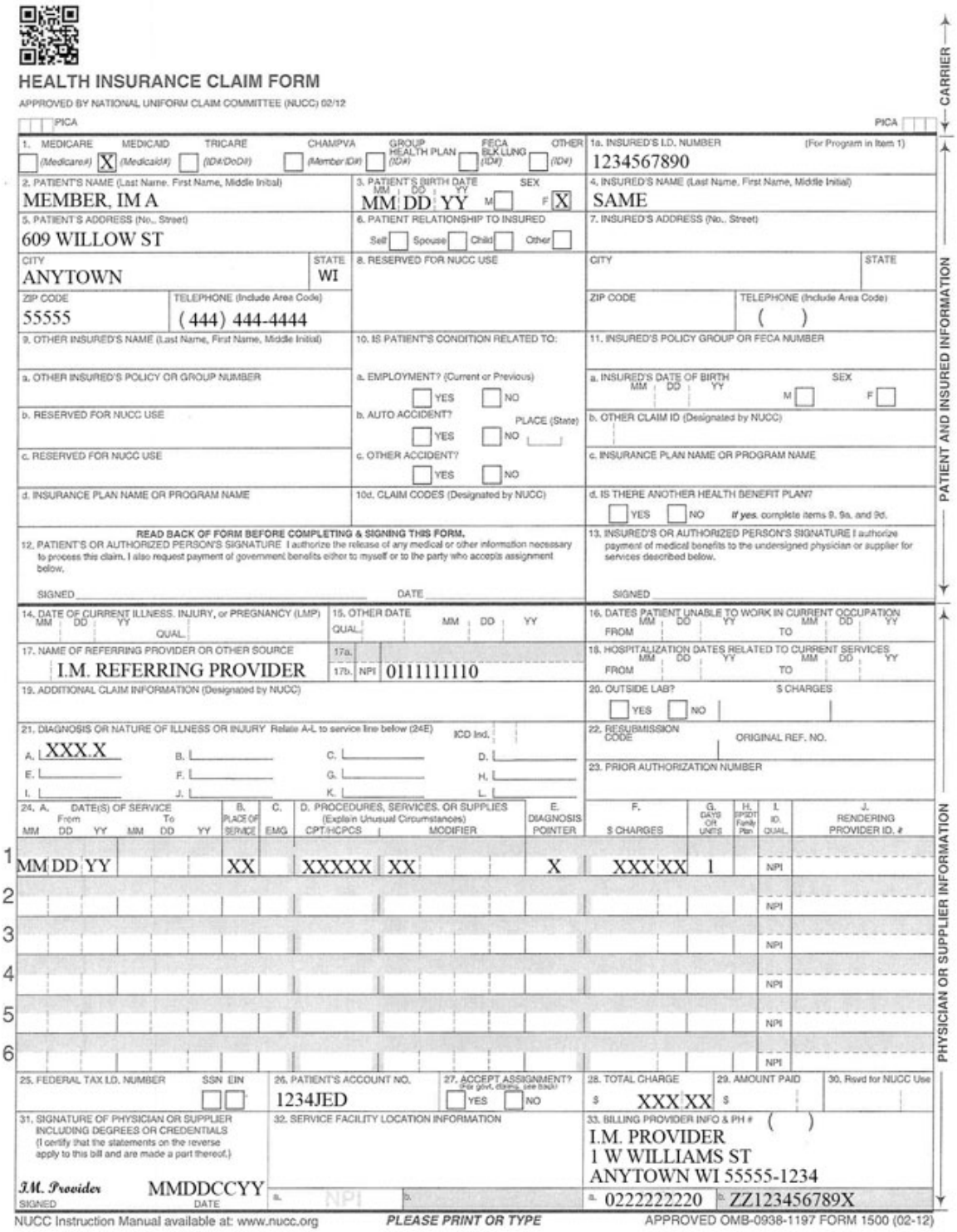
Staples, Correction Liquid, and Correction Tape

The use of staples, correction liquid, correction tape, labels, or stickers on claim forms should be avoided. Staples need to be removed from claim forms before they can be imaged, which can damage the claim and cause a delay in processing time. Correction liquid, correction tape, labels, and stickers can cause data to be read incorrectly or cause the OCR process to stop, prompting manual review. If the form cannot be read by the OCR software, it will need to be keyed manually from an electronic image.

Additional Diagnosis Codes

ForwardHealth will accept up to 12 diagnosis codes in Item Number 21 of the 1500 Health Insurance Claim Form.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WI

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (444) 444-4444

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 0111111110

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		XX		XXXXX	XX	X	XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

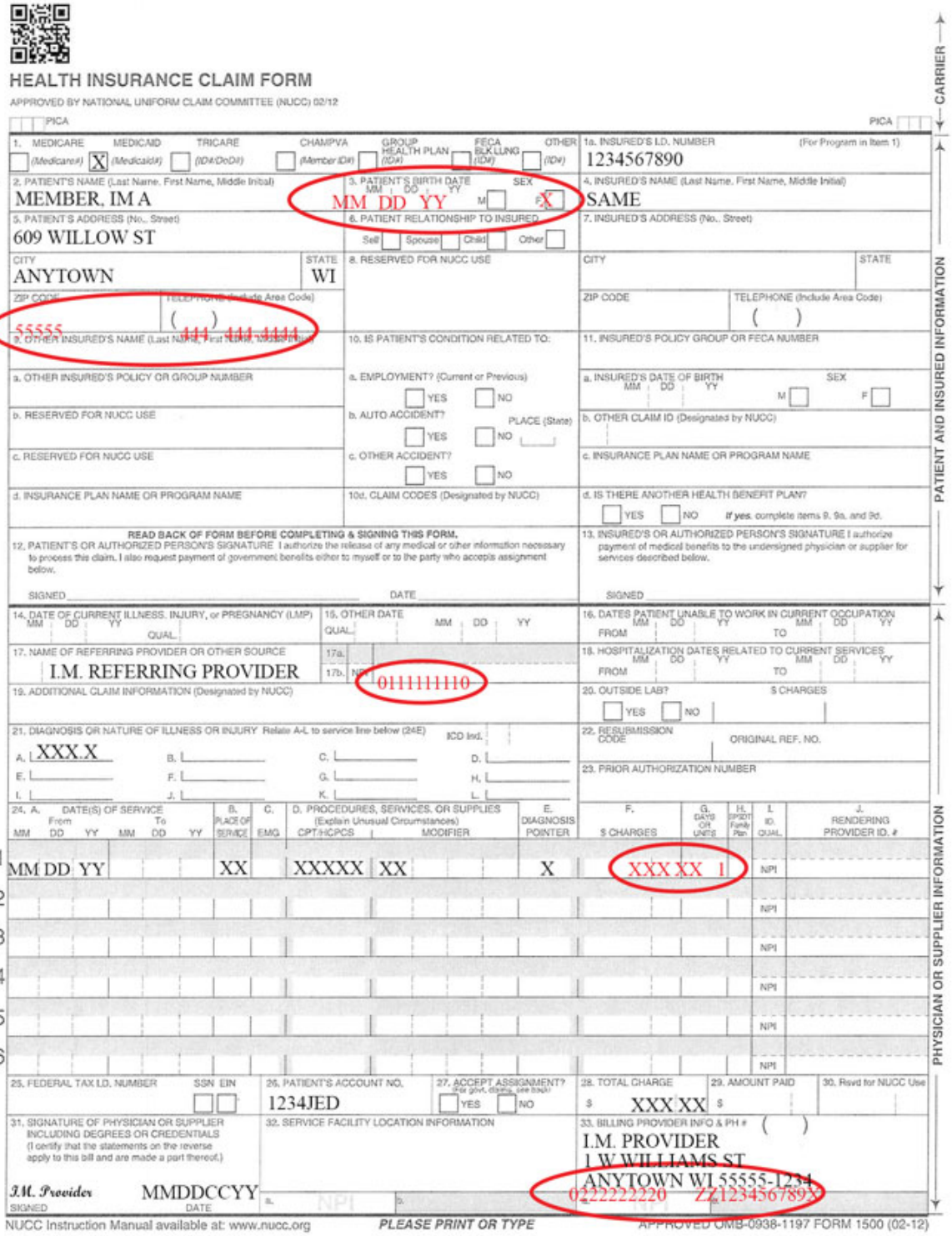
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): ( ) 111 111 1111

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 0111111110

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		XX		XXXXX	XX	X	XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
0222222220 ZZ123456789X

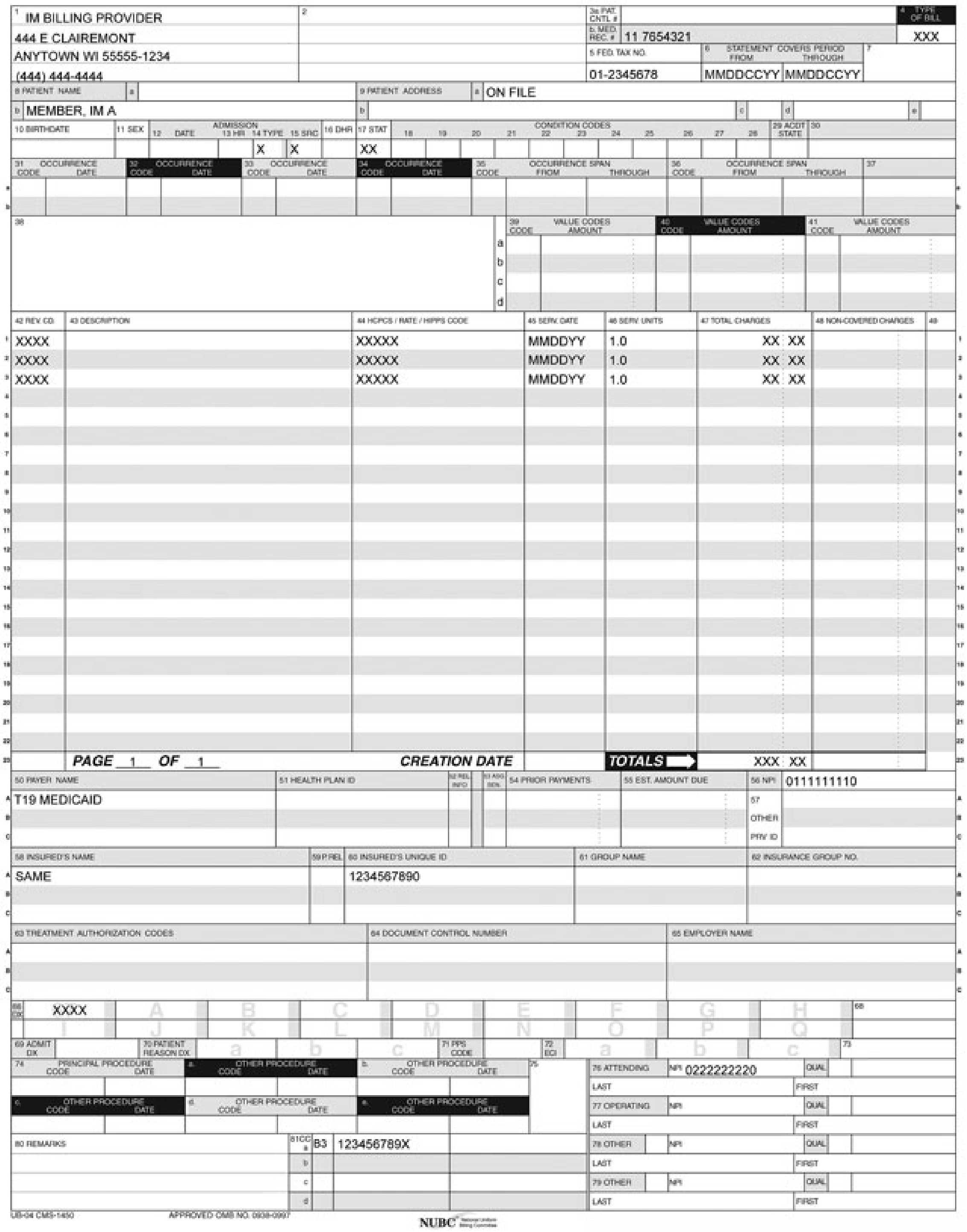
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444

3a PAT. CNTL #
b. MED. REC. # 11 7654321
4 TYPE OF BILL XXX
5 FED. TAX NO. 01-2345678
6 STATEMENT COVERS PERIOD FROM MMDDCCYY THROUGH MMDDCCYY

8 PATIENT NAME b MEMBER, IM A
9 PATIENT ADDRESS a ON FILE

10 BIRTHDATE
11 SEX
ADMISSION 12 DATE 13 HR 14 TYPE X 15 SRC X
16 DHR
17 STAT XX
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31–34 OCCURRENCE CODE DATE
35–36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39–41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXX XX		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0111111110
A T19 MEDICAID						57 OTHER PRV ID

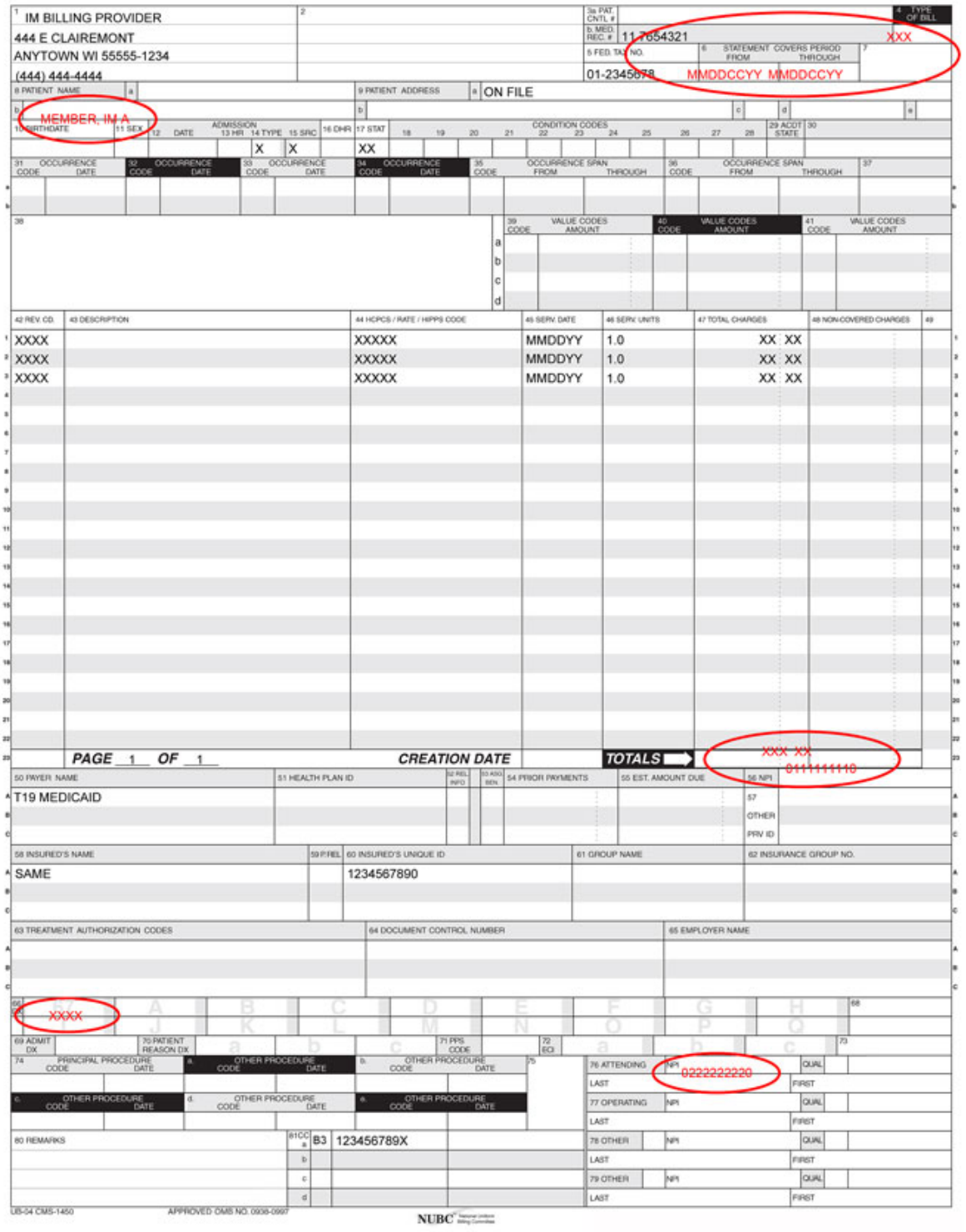
58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A SAME		1234567890		

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX XXXX
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE; a.–e. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI 0222222220 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC a B3 123456789X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #2168

Paper Claim Submission

Paper claims for all home health services (except for DME (durable medical equipment) and DMS (disposable medical supplies)) must be submitted using the UB-04 paper claim form. Claims for home health services submitted on any other claim form will be denied.

Providers should use the UB-04 claim form instructions for home health services when submitting these claims. Do not attach documentation to the claim unless it is specifically required.

Obtaining the Claim Forms

ForwardHealth does not provide the UB-04 claim form. The forms may be obtained from any federal forms supplier.

Durable Medical Equipment and Disposable Medical Supplies

Providers submitting paper claims for DME and DMS are required to use the 1500 Health Insurance Claim Form ((02/12)). The DME service area and the DMS service area provide claims submission information, as well as policy and PA (prior authorization) information.

Topic #22797

Payment Integrity Review Supporting Documentation

Providers are notified that an individual claim is subject to PIR (payment integrity review) through a message on the Portal when submitting claims. When this occurs, providers have seven calendar days to submit the supporting documentation that must be retained in the member's record for the specific service billed. This documentation must be attached to the claim. The following are examples of documentation providers may attach to the claim; however, this list is not exhaustive, and providers may submit any documentation available to substantiate payment:

- Case management or consultation notes
- Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- Face-to-face encounter documentation
- Individualized plans of care and updates
- Initial or program assessments and questionnaires to indicate the start DOS (date of service)
- Office visit documentation
- Operative reports
- Prescriptions or test orders
- Session or service notice for each DOS
- Testing and lab results
- Transportation logs
- Treatment notes

Providers must attach this documentation to the claim at the time of, or up to seven days following, submission of the claim. A claim may be denied if the supporting documentation is not submitted. If a claim is denied, providers may submit a new claim with the required documentation for reconsideration. To reduce provider impact, claims reviewed by the OIG (Office of the Inspector General) will be processed as quickly as possible, with an expected average adjudication of 30 days.

Topic #10177

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA (prior authorization) number on claims. ForwardHealth interChange matches the claim

with the appropriate approved PA request. ForwardHealth's RA (Remittance Advice) and the 835 (835 Health Care Claim Payment/Advice) report to the provider the PA number used to process a claim. If a PA number is indicated on a claim, it will not be used, and it will have no effect on processing the claim.

When a PA requirement is added to the list of drugs requiring PA and the effective date of a PA falls in the middle of a billing period, two separate claims that coincide with the presence of PA for the drug must be submitted to ForwardHealth.

Topic #10637

Reimbursement Reduction for Most Paper Claims

As a result of the Medicaid Rate Reform project, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject up to a $1.10 reimbursement reduction per claim.

For each claim that a reimbursement reduction was applied, providers will receive an EOB (Explanation of Benefits) to notify them of the payment reduction. For claims with reimbursement reductions, the EOB will state the following, "This claim is eligible for electronic submission. Up to a $1.10 reduction has been applied to this claim payment."

If a paid claim's total reimbursement amount is less than $1.10, ForwardHealth will reduce the payment up to a $1.10. The claim will show on the RA (Remittance Advice) as paid but with a $0 paid amount.

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/2017)) form
- Noncompound Drug Claim (F-13072 (02/2025)) form

Exceptions to Paper Claim Reimbursement Reduction

The reimbursement reduction will not affect the following providers or claims:

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/2013)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (DMS-1000 (05/2025)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/2015)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/2014)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #15977

Submitting Multiple National Drug Codes per Procedure Code

If two or more NDCs (National Drug Codes) are submitted for a single procedure code, the procedure code is required to be repeated on separate details for each unique NDC. Whether billing a compound or noncompound drug, the procedures for billing multiple components (NDCs) with a single HCPCS (Healthcare Common Procedure Coding System) code are the same.

Claim Submission Instructions for Claims With Two or Three National Drug Codes

When two NDCs are submitted on a claim, a KP modifier (first drug of a multiple drug unit dose formulation) is required on the first detail and a KQ modifier (second or subsequent drug of a multiple drug unit dose formulation) is required on the second detail.

For example, if a provider administers 150 mg of XYZ drug, and a 100 mg vial and a 50 mg vial were used, then the NDC from each vial must be submitted on the claim. Although the vials have different NDCs, the drug has one procedure code, Z1234. In this example, the same procedure code would be reported on two details of the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
Z1234	12345-6789-12	XYZ drug—100 mg
Z1234	12345-6789-34	XYZ drug—50 mg

Example 1500 Health Insurance Claim Form
for Submitting Two National Drug Codes per Procedure Code

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N412345678912 ME100															
	11	13	14	11	13	14	11		Z1234	KP	AC	500 00	2	N	NPI	0123456789
2	N412345678934 ME50															
	11	13	14	11	13	14	11		Z1234	KQ	AC	500 00	1	N	NPI	0123456789

When three NDCs are submitted on a claim, a KP modifier is required on the first detail, a KQ modifier on the second detail, and the modifier should be left blank on the third detail.

For example, if a provider administers a mixture of 1 mg of ABC drug, 125 mg of XYZ drug, and 50 ml of PRQ drug, each NDC is required on a separate detail. However, this compound drug formulation is required to be billed under one procedure code, J3490 (Unclassified drugs), and the same procedure code must be reported on three separate details on the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
J3490	11111-2222-33	ABC drug—1 mg
J3490	12345-6789-56	XYZ drug—125 mg
J3490	44444-5555-66	PRQ drug—50 ml

Example 1500 Health Insurance Claim Form
for Submitting Three National Drug Codes per Procedure Code

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N411111222233 ME1											
	11 13 14	11 13 14	11		J3490	KP	AC	500 00	1	N	NPI	0123456789
2	N412345678956 ME125											
	11 13 14	11 13 14	11		J3490	KQ	AC	500 00	1	N	NPI	0123456789
3	N444444555566 ML50											
	11 13 14	11 13 14	11		J3490		AC	500 00	1	N	NPI	0123456789

Claims for physician-administered drugs with two or three NDCs may be submitted to ForwardHealth via the following methods:

- The 837P (837 Health Care Claim: Professional) transaction
- PES (Provider Electronic Solutions) software
- DDE (Direct Data Entry) on the ForwardHealth Portal
- A 1500 Health Insurance Claim Form ((02/12))

Claim Submission Instructions for Claims with Four or More National Drug Codes

When four or more components are reported, each component is required to be listed separately in a statement of ingredients on an attachment that must be appended to a paper 1500 Health Insurance Claim Form.

Note: The reimbursement reduction for paper claims will not affect claims submitted on paper with four or more NDCs, as described above.

Topic #4817

Submitting Paper Attachments With Electronic Claims

Providers may submit paper attachments to accompany electronic claims and electronic claim adjustments. Providers should refer to their companion guides for directions on indicating that a paper attachment will be submitted by mail.

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page (F-13470 (03/2023)). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between two and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

ForwardHealth will hold an electronic claim transaction or a paper attachment(s) for up to seven calendar days to find a match. If a match cannot be made within seven days, the claim will be processed without the attachment and will be denied if an attachment is required. When such a claim is denied, both the paper attachment(s) and the electronic claim will need to be resubmitted.

Providers are required to send paper attachments relating to electronic claim transactions to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #3885

UB-04 (CMS 1450) Claim Form Completion Instructions for Home Health Services

Use the following claim form completion instructions, not the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for BadgerCare Plus. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the NUBC (National Uniform Billing Committee). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling 312-422-3390 or by accessing the NUBC website.

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal for more information about verifying enrollment.

Note: Every code used on this claim form, even if the code is entered in a non-required form locator, is required to be a valid code. In addition, each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

When submitting paper claims, if the member has any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources, providers are required to complete and submit an Explanation of Medical Benefits form, along with the completed paper claim.

Submit completed paper claims and the completed Explanation of Medical Benefits form, as applicable, to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Form Locator 1 — Provider Name, Address, and Telephone Number
Enter the name of the provider submitting the claim and the provider's complete practice location address. The minimum requirement is the provider's name, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The name in Form Locator 1 must correspond with the NPI (National Provider Identifier) in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)
Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on BadgerCare Plus remittance information.

Form Locator 3b — Med. Rec. # (optional)
Enter the number assigned to the patient's medical/health record by the provider. This number will appear on BadgerCare Plus remittance information.

Form Locator 4 — Type of Bill
Enter the three-digit type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The

third digit indicates the billing frequency. Providers of home health services should use one of the following type of bill codes:

32X: Home Health — Services under a plan of treatment

- 321: Inpatient admit through discharge claim
- 322: Interim bill — first claim
- 323: Interim bill — continuing claim
- 324: Interim bill — final claim

34X: Home Health — Services not under a plan of treatment

- 341: Inpatient admit through discharge claim
- 342: Interim bill — first claim
- 343: Interim bill — continuing claim
- 344: Interim bill — final claim

Form Locator 5 — Fed. Tax No.
Data are required in this form locator for OCR (Optical Character Recognition) processing. Any information populated by a provider's computer software is acceptable data for this form locator. If computer software does not automatically complete this form locator, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8 a-b — Patient Name
Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin's EVS (Enrollment Verification System) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Form Locator 9 a-e — Patient Address
Data are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (for example, "Same"). If computer software does not automatically complete this form locator, enter information such as the member's complete address in field 9a.

Form Locator 10 — Birthdate
Enter the member's birth date in MMDDCCYY format (for example, September 25, 1975, would be 09251975).

Form Locator 11 — Sex
Specify that the member is male with a "M" or female with a "F." If a member's sex is unknown, enter "U."

Form Locator 12 — Admission Date (not required)

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Priority (Type) of Admission or Visit
Enter the appropriate admission type for the services rendered. Refer to the UB-04 Billing Manual for more information.

Form Locator 15 — Point of Origin for Admission or Visit
Enter the code indicating the source of this admission. Refer to the UB-04 Billing Manual for more information.

Form Locator 16 — DHR (not required)

Form Locator 17 — Patient Discharge Status (not required)

Form Locators 18-28 — Condition Codes (required, if applicable)
Enter a code(s) to identifying conditions relating to this claim, if appropriate. Refer to the UB 04 Uniform Billing Manual for a list of condition codes.

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locator 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.
Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to home health services publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description
Do not enter any dates in this form locator.

Form Locator 44 — HCPCS/Rate/HIPPS Code
Enter the appropriate five-digit procedure code, followed by the modifiers. Modifiers may include start-of-shift modifiers and subsequent visit modifiers. No more than four modifiers per detail line may be entered. Separate the modifier(s) with commas. Refer to the Online Handbook for appropriate modifiers.

Form Locator 45 — Serv. Date
Enter the single "from" DOS (date of service) in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units
Enter the number of covered accommodations, ancillary units of service, or visits, where appropriate.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)
Enter the usual and customary charges pertaining to the related procedure code for the current billing period as entered in Form Locators 43 and 45.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field
Enter the "to" DOS in DD format. A range of consecutive dates may be indicated only if the revenue code, the procedure code (and modifiers, if applicable), the service units, and the charge were identical for each date within the range.

Detail Line 23

PAGE ___ OF ___

Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS
Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (the sum of all details from all pages of the claim) **only on the last page of the claim**.

Form Locator 50 A-C — Payer Name
Enter all health insurance payers here. Enter "T19" for Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the **first page** of the claim.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel. Info (not required)

Form Locator 53 A-C — Asg. Ben. (not required)

Form Locator 54 A-C — Prior Payments (not required)
This information is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer listed in Form Locator 50 A-C as an attachment(s) to their completed claim.

Form Locator 55 A-C — Est. Amount Due (not required)

Form Locator 56 — NPI
Enter the provider's NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured's Name
Data are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (for example, "Same"). If computer software does not automatically complete this form locator, enter information such as the member's last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured's Unique ID
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — Dx (not required)

Form Locator 67 — Principal Diagnosis Code and Present on Admission Indicator
Enter the valid, most specific ICD (International Classification of Diseases) code describing the principal diagnosis (for example, the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include External Cause of Morbidity codes.

Form Locators 67A-Q —Other Diagnosis Codes and Present on Admission Indicator
Enter valid, most specific ICD diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx (not required)

Form Locator 70 — Patient Reason Dx (not required)

Form Locator 71 — PPS Code (not required)

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending
Enter the attending physician's NPI. In addition, include the last and first name of the attending physician.

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other Provider Name and Identifiers
Enter the referring provider's NPI, followed by "DN" in the qualifier field and the last and first names of the provider in the appropriate fields. If a rendering provider is required on the claim, enter the rendering provider's NPI, followed by "82" in the qualifier field and the last and first names of the provider in the appropriate fields.

Form Locator 80 — Remarks (not required)

Commercial Health Insurance Billing Information

This information is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate

Explanation of Medical Benefits form for each other payer listed in Form Locator 50 A-C as an attachment(s) to their completed claim.

Form Locator 81 a-d — CC
If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth in the second field.

Note: Providers should use qualifier "PXC" when submitting an electronic claim using the 837I (837 Health Care Claim: Institutional) transaction. For further instructions, refer to the companion guide for the 837I transaction.

Topic #11677

Uploading Claim Attachments via the Portal

Providers are able to upload attachments for most claims via the secure Provider area of the ForwardHealth Portal. This allows providers to submit all components for claims electronically.

Providers are able to upload attachments via the Portal when a claim is suspended and an attachment was indicated but not yet received. Providers are able to upload attachments for any suspended claim that was submitted electronically. Providers should note that all attachments for a suspended claim must be submitted within the same business day.

Claim Types

Providers will be able to upload attachments to claims via the Portal for the following claim types:

- Professional
- Institutional
- Dental

The submission policy for compound and noncompound drug claims does not allow attachments.

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (.jpg or .jpeg)
- PDF (.pdf)
- Rich Text Format (.rtf)
- Text File (.txt)

JPEG files must be stored with a .jpg or .jpeg extension; text files must be stored with a .txt extension; rich text format files must be stored with a .rtf extension; and PDF files must be stored with a .pdf extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

When a provider submits a DDE (Direct Data Entry) claim and indicates an attachment will also be included, a feature button will appear and link to the DDE claim screen where attachments can be uploaded.

Providers are still required to indicate on the DDE claim that the claim will include an attachment via the Attachments panel.

Claims will suspend for seven days before denying for not receiving the attachment.

Claims Submitted by Provider Electronic Software and 837 Health Care Claim Transactions

Providers submitting claims via 837 (837 Health Care Claim) transactions are required to indicate attachments via the PWK segment. Providers submitting claims via PES (Provider Electronic Solutions) software will be required to indicate attachments via the attachment control field. Once the claim has been submitted, providers will be able to search for the claim on the Portal and upload the attachment via the Portal. Refer to the Implementation Guides for how to use the PWK segment in 837 transactions and the PES Manual for how to use the attachment control field.

Claims will suspend for seven days before denying for not receiving the attachment.

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to mail ForwardHealth a Timely Filing Appeals Request (F-13047 (08/2015)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (02/2025)) form to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

DOS (dates of service) that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing and late DOS will be denied.

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (08/2015)) cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Topic #744

Submission

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request (F-13047 (08/2015)) form for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- A legible claim or Adjustment/Reconsideration Request (F-13046 (02/2025)) form
- All required documentation as specified for the exception to the submission deadline
- A properly completed Explanation of Medical Benefits form for paper claims and paper claim adjustments where other health insurance sources are indicated

Note: Providers are reminded to complete and submit the most current versions of these forms supported by ForwardHealth.

To receive consideration for an exception, a Timely Filing Appeals Request form must be received by ForwardHealth before the applicable submission deadlines specified for the exception.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS (place of service) code, and all other required claims data elements effective for the DOS (date of service). However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

The following table lists the filing deadlines and additional documentation requirements as they correspond to each of the eight allowable exceptions.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized LOC (level of care) or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request form. - The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment. - A copy of the Explanation of Medical Benefits form, if applicable.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Decision Made by a Court, Fair Hearing, or the Wisconsin Department of Health Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the Wisconsin DHS (Department of Health Services).	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. Include the following documentation as part of the request: - A complete copy of the decision notice received from the court, fair hearing, or DHS	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: - A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. - A photocopy of **one** of the following indicating enrollment on the DOS:	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	¡ Temporary Identification Card for Express Enrollment in BadgerCare Plus ¡ Temporary Identification Card for Express Enrollment in Family Planning Only Services ¡ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ¡ The transaction log number received through WiCall ¡ The enrollment tracking number received through the ForwardHealth Portal	
ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. Include the following documentation as part of the request: ı A copy of the RA message that shows the ForwardHealth-initiated adjustment ı A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the income maintenance or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. Include the following documentation as part of the request: ı A copy of the Explanation of Medical Benefits form, if applicable **And** ı GR retroactive enrollment indicated on the claim **Or** ı A copy of the letter received from the income maintenance or tribal agency	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784
Medicare Denial Occurs After the Submission Deadline		

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: - The charges were previously submitted to Medicare. - The member name and identification number do not match. - The services were previously denied by Medicare. - The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: - A copy of the Medicare remittance information - A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Refund Request from an Other Health Insurance Source

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: - A copy of the recoupment notice - An updated Explanation of Medical Benefits form, if applicable Note: When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Retroactive Member Enrollment into Medicaid

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. In addition, retroactive enrollment	ForwardHealth Timely Filing Ste 50

determination of a member's retroactive enrollment.	must be indicated by selecting Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive period, if available) box on the Timely Filing Appeals Request (F-13047 (08/15)) form.	313 Blettner Blvd Madison WI 53784

Coordination of Benefits

2

Archive Date:08/03/2026

Coordination of Benefits:Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (for example, provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) companies may permit reimbursement to the provider or member. Providers should verify whether other health insurance benefits may be assigned to the provider. As indicated by the other health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

If the provider is assigned benefits, providers should bill the other health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the other health insurance. In this instance providers should indicate the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. ForwardHealth will bill the other health insurance.

Topic #844

Claims for Services Denied by Commercial Health Insurance

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

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

Topic #598

Commercial Fee-for-Service

Fee-for-service commercial health insurance is the traditional health care payment system under which providers receive a payment for each unit of service provided rather than a capitation payment for each member. Such insurance usually does not restrict health care to a particular network of providers.

When commercial health insurance plans give the member the option of getting care within or outside a provider network, non-network providers **may** be reimbursed by the commercial health insurance company for covered services if they follow the commercial health insurance plan's billing rules.

Topic #601

Definition of Commercial Health Insurance

Commercial health insurance is defined as any type of health benefit not obtained from Medicare or Wisconsin Medicaid and BadgerCare Plus. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan.

Common types of commercial health insurance include HMOs, PPOs (preferred provider organizations), POS (point-of-service) plans, Medicare Advantage plans, Medicare supplemental plans, dental plans, vision plans, HRAs (health reimbursement accounts), and LTC (long term care) plans. Some commercial health insurance providers restrict coverage to a specified group of providers in a particular service area.

When commercial health insurance plans require members to use a designated network of providers, non-network (for example, providers who do not have a contract with the member's commercial health insurance plan) will be reimbursed by the commercial health insurance plan **only** if they obtain a referral or provide an emergency service.

Except for emergency services and covered services that are not covered under the commercial health insurance plan, members enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid (for example, state-contracted MCO (managed care organization), fee-for-service) are required to receive services from providers affiliated with the commercial health insurance plan. In this situation, providers are required to refer the members to the commercial health insurance plan's network providers. This is necessary because commercial health insurance is always primary to BadgerCare Plus.

BadgerCare Plus and Wisconsin Medicaid will **not** reimburse the provider if the commercial health insurance plan denied or would deny payment because a service otherwise covered under the commercial health insurance plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside their commercial health insurance plan, the provider cannot collect payment from the member.

Topic #602

Discounted Rates

Providers of services that are discounted by other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) should include the following information on claims or on the Explanation of Medical Benefits form, as applicable:

- Their usual and customary charge
- The appropriate claim adjustment reason code, NCPDP (National Council for Prescription Drug Programs) reject code, or other insurance indicator
- The amount, if any, actually received from other health insurance as the amount paid by other health insurance

Topic #596

Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Step 1. Determine if the Member Has Commercial Health Insurance

If Wisconsin's EVS (Enrollment Verification System) does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage.

If the member disputes the information as it is indicated in the EVS, the provider should submit a real-time Other Coverage Discrepancy Report via the ForwardHealth Portal or submit a completed Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

Step 2. Determine if the Service Requires Other Health Insurance Billing

If the service requires other health insurance billing, the provider should proceed to Step 3.

If the service does not require other health insurance billing, the provider should proceed in one of the following ways:

- The provider is encouraged to bill commercial health insurance if they believe that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.
- The provider may submit a claim without indicating an other insurance indicator on the claim or on the Explanation of Medical Benefits form, as applicable.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with Wisconsin Medicaid's ability to recover prior payments.

Step 3. Identify Assignment of Commercial Health Insurance Benefits

The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.)

The provider should proceed in one of the following ways:

- **If the provider is assigned benefits,** the provider should bill commercial health insurance and proceed to Step 4.
- **If the member is assigned insurance benefits,** the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from Wisconsin Medicaid and the member, the provider is required to return the lesser amount to Wisconsin Medicaid.

Step 4. Bill Commercial Health Insurance and Follow Up

If commercial health insurance denies or partially reimburses the provider for the claim, the provider may proceed to Step 5.

If commercial health insurance does not respond within 45 days, the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

Step 5. Submit Claim to ForwardHealth

If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim

to ForwardHealth using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

Topic #18497

Explanation of Medical Benefits Form Requirement

An Explanation of Medical Benefits (F-01234 (04/2018)) form must be included for each other payer when other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources are indicated on a paper claim or paper adjustment.

Note: ADA (American Dental Association) claims and claim adjustments and compound and noncompound drug claims and claim adjustments are **not** subject to the requirements regarding use of the Explanation of Medical Benefits form.

Paper claims or adjustment requests that have other health insurance indicated may be returned to the provider unprocessed or denied if they are submitted without the Explanation of Medical Benefits form for each other payer. Paper claims or adjustments submitted with incorrect or incomplete Explanation of Medical Benefits forms will also be returned or denied.

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 (for example, retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

The Explanation of Medical Benefits form requirement for paper claims and adjustments is intended to help ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or using an 837 (837 Health Care Claim) transaction (including those submitted using PES (Provider Electronic Solutions) software or through a clearinghouse or software vendor).

The Explanation of Medical Benefits form requirement applies to paper claims and paper adjustments submitted to Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and the WCDP (Wisconsin Chronic Disease Program). Providers are reminded that, except for a few instances, Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP are payers of last resort for any covered service. Therefore, providers are required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Wisconsin Medicaid and BadgerCare Plus are not payers of last resort for members who receive coverage from certain governmental programs. Providers should ask members if they have coverage from these other government programs.

If a member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus after the provider has already been reimbursed by one of these government programs, the provider may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Ink, Data Alignment, and Quality Standards for Paper Claim Submission

In order for OCR (Optical Character Recognition) software to read paper claim forms accurately, the claim forms must comply with certain ink standards, as well as other data alignment and quality standards. The Explanation of Medical Benefits form will also need to comply with these standards.

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

Sometimes a member's enrollment file shows commercial managed care coverage, but the member is unable to receive services from the managed care plan. Examples of such situations include the following:

- Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- Members enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.
- Members enrolled in a commercial managed care plan who enter a nursing facility that limits the member's access to managed care providers.

In these situations, Wisconsin Medicaid will reimburse services covered by both BadgerCare Plus or Medicaid and the commercial managed care plan even though the services are obtained from providers outside the plan.

When submitting claims for these members, providers should do one of the following:

- Indicate the other insurance information on the Explanation of Medical Benefits Form for paper claims.
- Refer to the Wisconsin PES (Provider Electronic Solutions) manual or the appropriate 837 (837 health care claim) companion guide to determine the appropriate other insurance indicator for electronic claims.

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

- Services covered by a commercial health insurance plan, except for coinsurance, copay, or deductible
- Services for which providers contract with a commercial health insurance plan to receive a capitation payment for services

Topic #605

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed according to Wisconsin Medicaid expectations. Providers are required to use these indicators as applicable on professional, institutional, or dental claims or on the Explanation of Medical Benefits form, as applicable, submitted for members with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement constitutes fraud.

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be reimbursed correctly when the following occur:

- Commercial health insurance exists, does not apply, or when, for some valid reason, the provider is unable to obtain such reimbursement by reasonable means.
- Commercial health insurance does not cover the service provided.
- Full or partial payment was made by commercial health insurance.

Code	Description
OI-P	PAID in part or in full by commercial health insurance, and/or was applied toward the deductible,

	coinsurance, copay, blood deductible, or psychiatric reduction. Indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance following submission of a correct and complete claim. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance coverage, but it was not billed for reasons including, but not limited to, the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copay and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Providers should not use other insurance indicators when the following occur:

- Wisconsin's EVS (Enrollment Verification System) indicates no commercial health insurance for the DOS (date of service).
- The service does not require other health insurance billing.
- Claim denials from other payers relating to NPI (National Provider Identifier) and related data should be resolved with that payer and not submitted to ForwardHealth. Payments made in these situations may be recouped.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill commercial health insurance sources to substantiate other insurance indicators used on any claim, according to Wis. Admin. Code § DHS 106.02(9)(a).

Topic #603

Services Not Requiring Commercial Health Insurance Billing

Providers are not required to bill commercial health insurance sources before submitting claims for the following:

- Case management services
- CCS (Comprehensive Community Services)
- Crisis Intervention services
- CRS (Community Recovery Services)
- CSP (Community Support Program) services
- Family planning services
- In-home mental health/substance abuse treatment services for children (HealthCheck Other Services) rendered by providers at the less than bachelor's degree level, bachelor's degree level, QTT (qualified treatment trainee) level, or

certified psychotherapist level
- Personal care services
- PNCC (prenatal care coordination) services
- Preventive pediatric services
- SMV (specialized medical vehicle) services

Topic #769

Services Requiring Commercial Health Insurance Billing

If ForwardHealth indicates that the member has other commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ambulance services, if provided as emergency services
- Anesthetist services
- Audiology services, unless provided in a nursing home or SNF (skilled nursing facility)
- Behavioral treatment
- Blood bank services
- Chiropractic services
- Dental services
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10 per item
- Home health services (excluding PC (personal care) services)
- Hospice services
- Hospital services, including inpatient or outpatient
- Independent nurse, nurse practitioner, or nurse midwife services
- Laboratory services
- Medicare-covered services for members who have Medicare and commercial health insurance
- In-home mental health/substance abuse treatment services for children (HealthCheck Other Services) rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- Outpatient mental health/substance abuse services
- Mental health/substance abuse day treatment services, including child and adolescent day treatment
- Narcotic treatment services
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF
- Physician assistant services
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient (however, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing)
- Pharmacy services for members with verified drug coverage
- Podiatry services
- PDN (private duty nursing) services
- Radiology services
- RHC (rural health clinic) services
- Skilled nursing home care, if any DOS (date of service) is within 120 days of the date of admission; if benefits greater than 120 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted
- Vision services over $50, unless provided in a home, nursing home, or SNF

If ForwardHealth indicates the member has other vision coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services

- Optometrist services

If ForwardHealth indicates the member has Medicare supplemental plan coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Alcohol, betadine, and/or iodine provided by a pharmacy or medical vendor
- Ambulance services
- Ambulatory surgery center services
- Breast reconstruction services
- Chiropractic services
- Dental anesthesia services
- Home health services (excluding PC services)
- Hospital services, including inpatient or outpatient
- Medicare-covered services
- Osteopath services
- Physician services
- Skilled nursing home care, if any DOS is within 100 days of the date of admission; if benefits greater than 100 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted

ForwardHealth has identified services requiring Medicare Advantage billing.

Medicare

Topic #664

Acceptance of Assignment

In Medicare, **assignment** is a process through which a provider agrees to accept the Medicare-allowed amount as payment in full. A provider who agrees to this amount is said to **accept assignment**.

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member is required to accept assignment of the member's Medicare Part A benefits. Therefore, Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (for example, any amount paid by other health insurance sources, any copay or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount.

Topic #666

Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to ForwardHealth.

Topic #668

Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (for example, Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator or Explanation of Medical Benefits form, as applicable.

Topic #670

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, professional, institutional, and dental claims should be submitted to ForwardHealth without first submitting them to Medicare in the following situations:

- The provider cannot be enrolled in Medicare.
- The service is not allowed by Medicare under any circumstance. Providers should note that claims are denied for services that Medicare has determined are not medically necessary.

In these situations, providers should not indicate a Medicare disclaimer code on the claim.

Topic #704

Claims That Fail to Cross Over

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA (Remittance Advice). Claims with an NPI (National Provider Identifier) that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

ForwardHealth is not able to identify the billing provider on automatic crossover claims submitted by health care providers in the following situations:

- The billing provider's NPI has not been reported to ForwardHealth.
- The taxonomy code has not been reported to ForwardHealth or is not indicated on the automatic crossover claim.
- The billing provider's practice location ZIP+4 code on file with ForwardHealth is required to identify the provider and is not indicated on the automatic crossover claim.

If automatic crossover claims do not appear on the ForwardHealth and/or the MCO's (managed care organization) RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, copay, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- Medicare Part A fiscal intermediary
- Medicare Part B carrier
- Medicare DME (durable medical equipment) regional carrier
- Medicare Advantage Plan or Medicare Cost Plan
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier)

There are two types of crossover claims based on who submits them:

- Automatic crossover claims

- Provider-submitted crossover claims

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC (Coordination of Benefits Contractor).

Claims will be forwarded if the following occur:

- Medicare has identified that the services were provided to a dual eligible or a QMB-Only member.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan.

Providers are advised to wait 30 days before billing for claims submitted to Medicare to allow time for the automatic crossover process to complete. If automatic crossover claims do not appear on the ForwardHealth and/or the MCO (managed care organization)'s RA (Remittance Advice) after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI (National Provider Identifier) that was reported to ForwardHealth as the primary NPI.

If the service is covered by the MCO, the ForwardHealth RA will indicate EOB (Explanation of Benefits) code 0287 (Member is enrolled in a State-contracted managed care program). If the service is covered on a fee-for-service basis, the MCO RA will indicate that the service is not covered. If the crossover claim is submitted without error, the responsible entity (either ForwardHealth or the MCO) will process the claim to a payable status.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically cross over. Providers should submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim does not appear on the ForwardHealth or MCO RA within 30 days of the Medicare processing date.
- The automatic crossover claim is denied, and additional information may allow payment.
- The claim is for a member who was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- The claim is for a member who is enrolled in a Medicare Advantage Plan or Medicare Cost Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (for example, Medicare Supplemental).

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- The NPI that ForwardHealth has on file for the provider
- The taxonomy code that ForwardHealth has on file for the provider
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth

Providers may initiate a provider-submitted claim in one of the following ways:

- DDE (Direct Data Entry) through the ForwardHealth Provider Portal
- 837I (837 Health Care Claim: Institutional) transaction, as applicable
- 837P (837 Health Care Claim: Professional) transaction, as applicable
- PES (Provider Electronic Solutions) software

- Paper claim form

Topic #672

Definition of Medicare

Medicare is a health insurance program for people 65 years of age or older, for certain people with disabilities under age 65, and for people with ESRD (end-stage renal disease). Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- Part A (Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (for example, small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health services.
- Part B (Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (Medicare Advantage). A commercial health plan that acts for Medicare Parts A and B, and sometimes Medicare Part D, for all Medicare covered services except hospice. Medicare Part A continues to provide coverage for hospice services. There are limitations on coverage outside of the carrier's provider network.
- Part D (drug benefit).

Topic #684

Dual Eligibles

Dual eligibles are members who are eligible for coverage from Medicare (either Medicare Part A, Part B, or both) **and** Wisconsin Medicaid or BadgerCare Plus.

Dual eligibles may receive coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both
- Coinsurance, copay, and deductible for Medicare-allowed services
- BadgerCare Plus or Medicaid-covered services, even those that are not allowed by Medicare

Topic #669

Exhausting Medicare Coverage

Providers are required to exhaust Medicare coverage before submitting claims to ForwardHealth. This is accomplished by following these instructions. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim.

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request (F-13046 (02/2025)) form, the provider should complete and submit the Explanation of Medical Benefits form, as applicable.

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
- ForwardHealth denied the automatic crossover claim, and additional information may allow payment.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (**for example**, Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*

When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in addition to the following:

- For electronic claims, indicate the Medicare payment.
- For paper claims, complete the Explanation of Medical Benefits form.

When submitting provider-submitted crossover claims for members enrolled in Medicare and commercial health insurance that is secondary to Medicare, the provider is also required to do the following:

- Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
- Indicate the appropriate other insurance indicator on the claim or the Explanation of Medical Benefits form, as applicable.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the Timely Filing Appeals Request (F-13047 (08/2015)) form and Explanation of Medical Benefits form, as applicable. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare

When Medicare denies payment for a service provided to a dual eligible that is covered by BadgerCare Plus or Wisconsin Medicaid, the provider may proceed as follows:

- Bill commercial health insurance, if applicable.
- Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator on the claim or the Explanation of Medical Benefits form, as applicable. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed

A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occurred:

- Medicare reconsiders services that were previously not allowed.
- Medicare retroactively determines a member eligible.

In these situations, the provider should proceed as follows:

- Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.

- Bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-Only) members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage Plans have a special arrangement with the federal CMS (Centers for Medicare and Medicaid Services) and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

ForwardHealth has identified services requiring Medicare Advantage billing.

Paper Crossover Claims

Providers are required to complete and submit an Explanation of Medical Benefits form, along with provider-submitted paper crossover claims for services provided to members enrolled in a Medicare Advantage Plan.

Reimbursement Limits

Reimbursement limits on Medicare Part B services are applied to all Medicare Advantage Plan copay amounts in accordance with federal law. This may reduce reimbursement amounts in some cases.

Topic #20677

Medicare Cost

Providers are required to bill the following services to the Medicare Cost Plan before submitting claims to ForwardHealth if the member was enrolled in the Medicare Cost Plan at the time the service was provided:

- Ambulance services
- ASC (ambulatory surgery center) services
- Chiropractic services
- Dental anesthesia services
- Home health services (excluding PC (personal care) services)
- Hospital services, including inpatient or outpatient
- Medicare-covered services
- Osteopath services
- Physician services

Providers who are not within the member's Medicare Cost network and are not providing an emergency service or Medicare-allowed service with a referral may submit a claim to traditional Medicare Part A or Medicare Part B for the Medicare-allowed service prior to billing ForwardHealth.

Topic #688

Medicare Disclaimer Codes

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles. Refer to claim instructions for Medicare disclaimer codes and their descriptions. The intentional misuse of Medicare disclaimer codes to obtain inappropriate reimbursement from ForwardHealth constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by ForwardHealth when Medicare benefits exist or when, for some valid reason, the provider is unable to obtain such benefits by reasonable means.

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim **directly** to ForwardHealth using the appropriate Medicare disclaimer code on the claim or the Explanation of Medical Benefits form, as applicable.

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, or yearly allotment of available benefits is exhausted. **For Medicare Part A, use M-7 in the following instances (all three criteria must be met):** - The provider is identified in ForwardHealth files as enrolled in Medicare Part A. - The member is eligible for Medicare Part A. - The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. **For Medicare Part B, use M-7 in the following instances (all three criteria must be met):** - The provider is identified in ForwardHealth files as enrolled in Medicare Part B. - The member is eligible for Medicare Part B. - The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. **For Medicare Part A, use M-8 in the following instances (all three criteria must be met):** - The provider is identified in ForwardHealth files as enrolled in Medicare Part A. - The member is eligible for Medicare Part A. - The service is usually covered by Medicare Part A but not in this circumstance (for example, member's diagnosis). **For Medicare Part B, use M-8 in the following instances (all three criteria must be met):** - The provider is identified in ForwardHealth files as enrolled in Medicare Part B. - The member is eligible for Medicare Part B. - The service is usually covered by Medicare Part B but not in this circumstance (for example, member's diagnosis).

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim, according to Wis. Admin. Code § DHS 106.02(9)(a).

Topic #8457

Medicare Late Fees

Medicare assesses a late fee when providers submit a claim after Medicare's claim submission deadline has passed. Claims that cross over to ForwardHealth with a Medicare late fee are denied for being out of balance. To identify these claims, providers should reference the Medicare remittance information and check for ANSI (American National Standards Institute) code B4 (late filing penalty), which indicates a late fee amount deducted by Medicare.

ForwardHealth considers a late fee part of Medicare's paid amount for the claim because Medicare would have paid the additional amount if the claim had been submitted before the Medicare claim submission deadline. ForwardHealth will not reimburse providers for late fees assessed by Medicare.

Resubmitting Medicare Crossover Claims with Late Fees

Providers may resubmit to ForwardHealth crossover claims denied because the claim was out of balance due to a Medicare late fee. The claim may be submitted on paper, submitted electronically using the ForwardHealth Portal, or submitted as an 837 (837 Health Care Claim) transaction.

Paper Claim Submissions

When resubmitting a crossover claim on paper, include a copy of the Medicare remittance information so ForwardHealth can determine the amount of the late fee and apply the correct reimbursement amount.

Electronic Claim Submissions

When resubmitting a claim via the Portal or an electronic 837 transaction (including PES (Provider Electronic Solutions) software submissions), providers are required to balance the claim's paid amount to reflect the amount Medicare would have paid before Medicare subtracted a late fee. This is the amount that ForwardHealth considers when adjudicating the claim. To balance the claim's paid amount, add the late fee to the paid amount reported by Medicare. Enter this amount in the Medicare paid amount field.

For example, the Medicare remittance information reports the following amounts for a crossover claim:

- Billed Amount: $110
- Allowed Amount: $100
- Coinsurance: $20
- Late Fee: $5
- Paid Amount: $75

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of $5 to the paid amount of $75 for a total of $80. The claim should report the Medicare paid amount as $80.

Topic #689

Medicare Provider Enrollment

Some providers may become retroactively enrolled in Medicare. Providers should contact Medicare for more information about retroactive enrollment.

Services for Dual Eligibles

As stated in Wis. Admin. Code § DHS 106.03(7), a provider is required to be enrolled in Medicare if both of the following are true:

- They provide a Medicare Part A service to a dual eligible.
- They can be enrolled in Medicare.

If a provider can be enrolled in Medicare but chooses **not** to be, the provider is required to refer dual eligibles to another Medicaid-enrolled provider who is enrolled in Medicare.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-Only (Qualified Medicare Beneficiary-Only) members receive coverage from Wisconsin Medicaid only for services allowed by Medicare, providers who are not enrolled in Medicare are required to refer QMB-Only members to another Medicaid-enrolled provider who is enrolled in Medicare.

Topic #690

Medicare Retroactive Eligibility — Member

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any payments for the retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Topic #692

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They are eligible for coverage from Medicare (either Part A, Part B, or both) **and** limited coverage from Wisconsin Medicaid. QMB-Only members receive Medicaid coverage for the following:

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

QMB-Only members do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare. Therefore, Wisconsin Medicaid will not reimburse for services if either of the following occur:

- Medicare does not cover the service.
- The provider is not enrolled in Medicare.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copay of Medicare Part B-covered services provided to dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members.

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

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

The following table provides three examples of how the limitations are applied.

Reimbursement for Coinsurance or Copay of Medicare Part B-Covered Services			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (for example, maximum allowable fee)	$90	$110	$75
Medicare payment	$80	$80	$80
Medicaid payment	$10	$20	$0

Outpatient Hospital Crossover Claims

Detail-level information is used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles are paid in full.

Inpatient Hospital Services

State law limits reimbursement for coinsurance, copay and deductible of Medicare Part A-covered inpatient hospital services for dual eligibles and QMB-Only members.

Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (for example, any amount paid by other health insurance sources, any copay or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance, copay, and deductible of a Medicare Part A-covered inpatient hospital service is the **lesser** of the following:

- The difference between the **Medicaid**-allowed amount and the **Medicare**-paid amount.
- The sum of Medicare coinsurance, copay, and deductible.

The following table provides three examples of how the limitations are applied.

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles			
Explanation	Example		
	1	2	3
Provider's billed amount	$1,200	$1,200	$1,200
Medicare-allowed amount	$1,000	$1,000	$1,000
Medicaid-allowed amount (for example, diagnosis-related group or per diem)	$1,200	$750	$750
Medicare-paid amount	$1,000	$800	$500
Difference between Medicaid-allowed amount and Medicare-paid amount	$200	($-50)	$250
Medicare coinsurance, copay and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Nursing Home Crossover Claims

Medicare deductibles, coinsurance, and copays are paid in full.

Community Health Center and Tribal Federally Qualified Health Center Crossover Claims

CHC (Community health center) and Tribal FQHC (federally qualified health center) encounters subject to PPS (prospective payment system) and AIR (all-inclusive rate) reimbursement are carved out of (not included in) Medicare Crossover coverage.

Topic #770

Services Requiring Medicare Advantage Billing

Providers are required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services
- ASC (ambulatory surgery center) services
- Chiropractic services
- Dental anesthesia services
- Home health services (excluding PC (personal care) services)
- Hospital services, including inpatient or outpatient
- Medicare-covered services
- Osteopath services
- Physician services

Providers who are not within the member's Medicare Advantage network and are not providing an emergency service or Medicare-allowed service with a referral are required to refer the member to a provider within their network.

ForwardHealth has identified services requiring commercial health insurance billing.

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form, ForwardHealth confirms the information and updates the member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- The provider verifies through Wisconsin's EVS (Enrollment Verification System) that the member's other coverage information has been updated.
- The provider receives a written explanation.

Topic #4941

Coverage Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Topic #609

Insurance Disclosure Program

ForwardHealth receives policyholder files from most major commercial health insurance companies on a monthly basis. ForwardHealth then compares this information with member enrollment files. If a member has commercial health insurance, ForwardHealth revises the member's enrollment file with the most current information.

The insurance company is solely responsible for the accuracy of this data. If the insurance company provides information that is not current, ForwardHealth's files may be inaccurate.

Topic #610

Maintaining Accurate and Current Records

ForwardHealth uses many sources of information to keep accurate and current records of a member's other coverage, including the following:

- Insurance Disclosure program
- Providers who submit an Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form

- Member certifying agencies
- Members

The information about a member's other health insurance coverage in the member files may be incomplete or incorrect if ForwardHealth received inaccurate information from the other health insurance source or the member's certifying agency.

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by Wisconsin's EVS (Enrollment Verification System).
- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (for example, the member does not live in the plan's service area).

Providers should not use the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO (managed care organization).

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Provider-Based Billing

Topic #660

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in Wis. Admin. Code § DHS 106.03(7).

Topic #658

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at 608-243-0676. Providers may fax the corresponding Provider-Based Billing Summary to 608-221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are **not** within the 120-day limit, providers may call Provider Services.

Topic #661

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- A notification letter.
- A Provider-Based Billing Summary. The summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim and necessary information for providers to review and handle each claim.

If a member has coverage through multiple other health insurance sources, the provider may receive additional provider-based billing summaries and provider-based billing claims for each other health insurance source that is on file.

Accessing Provider-Based Billing Summary Reports

Providers can retrieve provider-based billing summary reports through the Portal by logging in to their secure provider Portal account. Once logged in, providers can click the Provider Based Bills (PBB) link located in the Quick Links box of the Providers area of the Portal to access the Provider Based Billing page. This page has links for the provider to download provider-based summary reports in .csv or .pdf format.

Refer to the Provider-Based Billing Retrieval User Guide for step-by-step instructions on how to access the Provider Based Billing page and download provider-based summary reports.

Note: ForwardHealth also sends the paper provider-based billing summary report to the provider's "mail to" address on file in the Portal.

The provider-based billing process runs monthly on the first full weekend of every month, and files are available once the process is completed.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS (dates of service) that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do **not** use the provider-based billing summary).	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	• A Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do **not** use the provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

	◦ The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	
The other health insurance source denies the provider-based billing claim.	◦ A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial **and** follow-up provider-based billing claim.	◦ A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	◦ A claim (do **not** use the provider-based billing summary). ◦ A Timely Filing Appeals Request (F-13047 (08/2015)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	◦ A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form. ◦ **After** using the EVS to verify that the member's other coverage information has been updated, include both of the following: ▪ A claim (do **not** use the provider-based billing summary.)	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address:

	¡ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	ı A claim (do **not** use the provider-based billing summary). ı Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	ı A claim. ı The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ı A Timely Filing Appeals Request form according to normal timely filing appeals procedures. ı The Provider-Based Billing Summary. ı Documentation of the denial, including any of the following: ¡ Remittance information from the other health insurance source. ¡ A written statement from the other health insurance source identifying the reason for denial. ¡ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ¡ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	▪ The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	▪ A claim (do **not** use the provider-based billing summary). ▪ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ▪ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Topic #662

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial **and** follow-up provider-based billing claim.

When responding to ForwardHealth within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the following table. If the provider's response to ForwardHealth does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or end-dated the other health insurance coverage from the member's file.	▪ The Provider-Based Billing Summary. ▪ Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567
The provider discovers that the member's other coverage information (enrollment dates) reported by the EVS is invalid.	▪ The Provider-Based Billing Summary. ▪ One of the following: ▪ The name of the person with whom the provider spoke and the member's correct other coverage information.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	¡ A printed page from an enrollment website containing the member's correct other coverage information.	
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	ı The Provider-Based Billing Summary. ı A copy of the remittance information received from the other health insurance source. ı The DOS (date of service), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. ı A copy of the Explanation of Medical Benefits form, as applicable. Note: In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567
The other health insurance source denies the provider-based billing claim.	ı The Provider-Based Billing Summary. ı Documentation of the denial, including any of the following: ¡ Remittance information from the other health insurance source. ¡ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ¡ Documentation indicating that the other health insurance source paid the member. ¡ A copy of the insurance card or other	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. ¡ A copy of the Explanation of Medical Benefits form, as applicable. l The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The other health insurance source fails to respond to the initial **and** follow-up provider-based billing claim.	l The Provider-Based Billing Summary. l Indication that no response was received by the other health insurance source. l Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

Topic #663

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider should add all information required by the other health insurance source to the claim. The providers should also attach additional documentation (for example, Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Topic #657

Billing Options

Providers may choose to seek payment from either of the following:

- Civil liabilities (for example, injuries from an automobile accident)
- Worker's compensation

However, as stated in Wis. Admin. Code § DHS 106.03(8), BadgerCare Plus and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Topic #829

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus or Wisconsin Medicaid, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Topic #826

Seeking Payment From Settlement

After choosing to seek payment from a settlement, the provider may **instead** submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Topic #827

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, they may not seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to ForwardHealth, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, ForwardHealth retains the sole right to recover medical costs.

Providers are required to indicate an accident-related diagnosis code on claims when services are provided to an accident victim. If the member has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to ForwardHealth.

Covered and Noncovered Services

3

Archive Date:08/03/2026

Covered and Noncovered Services:Codes

Topic #2164

Diagnosis Codes for Private Duty Nursing

ForwardHealth requires that all codes indicated on claims (and PA (prior authorization) requests when applicable) including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

All claims for PDN (private duty nursing) services provided to ventilator-dependent members must list ICD (International Classification of Diseases) diagnosis code Z99.11 (Dependence on respirator [ventilator] status) as the primary diagnosis code on the claim form. Wisconsin Medicaid will not reimburse claims for respiratory services without this code.

Claims for PDN services that do not include services provided to a ventilator-dependent member require a valid diagnosis code other than Z99.11 (Dependence on respirator [ventilator] status).

Topic #1079

Modifiers

All PDN (private duty nursing) and home health providers are required to use nationally recognized modifiers with procedure codes on PA (prior authorization) requests and claim forms. No more than four modifiers can be entered for each day on the UB-04 claim form.

Start-of-Shift Modifiers

Providers are required to use state-defined start of shift modifiers on claims for home health services and PDN services. Start-of-shift modifiers are not required on PA requests.

Providers should choose the start-of-shift modifier that most closely represents the time each shift began. For each day, enter the modifiers in the order of occurrence. If a single shift spans over midnight from one day to the next, providers are required to use two start-of-shift modifiers.

Professional Status Modifiers

For services to ventilator-dependent members, providers are required to use one of two nationally recognized modifiers to indicate the nurse's professional status. Professional status modifiers are required on PA requests and claims.

Topic #2162

Place of Service

When submitting PA (prior authorization) requests, providers are required to include a POS (place of service) code. Providers should choose the most appropriate POS when requesting PA. The following table lists examples of nationally recognized, two-

digit POS codes.

POS Code	Description
03	School
12	Home
99	Other Place of Service

Topic #2161

Prior Authorization Number

Each PA (prior authorization) request is assigned a unique ten-digit number. When the POC (plan of care) is updated at times other than requesting PA, including the PA number on the POC is optional. Including the PA number on a POC that is not being submitted with a PA request is optional. However, Wisconsin Medicaid recommends that providers include the PA number on the POC even when it is optional. A PA number has record keeping advantages for the providers on the case and will make the POC easier to reference in the future.

Topic #2160

Procedure Code and Modifier Table

The following table lists the HCPCS (Healthcare Common Procedure Coding System) and CPT (Current Procedural Terminology) procedure codes providers should use when submitting claims and PA (prior authorization) requests. The table also lists the modifiers that apply to each procedure code.

Note: All influenza virus vaccine and pneumococcal vaccine CPT procedure codes are covered under home health. No state-defined modifiers or state-defined start-of-shift modifiers are required for these procedure codes. Refer to Home Vaccination and Community Vaccination Clinics for more information about influenza and pneumococcal virus vaccines.

Procedure Code and Description (Limited to Medicaid-Covered Service)	State-Defined Modifier	State-Defined Start-of-Shift Modifier
92507—Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual [per visit] [ForwardHealth guidance: Indicate for home health speech therapy.]	None	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG—**Afternoon (12–5:59 p.m.) **UH—**Evening (6–11:59 p.m.)
97139—Unlisted therapeutic procedure (specify) [per visit] [ForwardHealth guidance: Indicate for home health occupational therapy.]	None	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG—**Afternoon (12–5:59 p.m.) **UH—**Evening (6–11:59 p.m.)
97799—Unlisted physical medicine/rehabilitation service or procedure [per visit] [ForwardHealth guidance: Indicate for home health physical therapy.]	None	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG—**Afternoon (12–5:59 p.m.) **UH—**Evening (6–11:59 p.m.)
99504—Home visit for mechanical ventilation care [per hour]	**TE**—LPN	**UJ**—Night (12–5:59 a.m.)

[ForwardHealth guidance: Indicate for private duty nurse—ventilation care.]	(licensed practical nurse)/LVN (licensed vocational nurse)	**UF**—Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
99504—Home visit for mechanical ventilation care [per hour] [ForwardHealth guidance: Indicate for private duty nurse—ventilation care.]	**TD**—RN (registered nurse)	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG —**Afternoon (12–5:59 p.m.) **UH —** Evening (6–11:59 p.m.)
99600—Unlisted home visit service or procedure [per visit] [ForwardHealth guidance: Indicate for home health intermittent skilled nursing visit.]	None	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
99600—Unlisted home visit service or procedure [per visit] [ForwardHealth guidance: Indicate for home health intermittent skilled nursing visit.]	**TS**—Follow-up service	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG—**Afternoon (12–5:59 p.m.) **UH—**Evening (6–11:59 p.m.)
S9123—Nursing care, in the home; by registered nurse, per hour [ForwardHealth guidance: Indicate for private duty registered nurse.]	None	**UJ**—Night (12–5:59 a.m.) **UF**—Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
S9124—Nursing care, in the home; by licensed practical nurse, per hour [ForwardHealth guidance: Indicate for private duty licensed practical nurse.]	None	**UJ**—Night (12–5:59 a.m.) **UF—**Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
T1001—Nursing assessment/evaluation [per visit]	None	**UJ**—Night (12–5:59 a.m.) **UF**—Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
T1021—Home health aide or certified nurse assistant, per visit	None	**UJ**—Night (12–5:59 a.m.) **UF**—Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
T1021—Home health aide or certified nurse assistant, per visit	**TS**—Follow-up service	**UJ**—Night (12–5:59 a.m.) **UF**—Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)
T1502—Administration of oral, intramuscular and/or subcutaneous	None	**UJ**—Night (12–5:59 a.m.)

medication by health care agency/professional, per visit		**UF**—Morning (6–11:59 a.m.) **UG**—Afternoon (12–5:59 p.m.) **UH**—Evening (6–11:59 p.m.)

Topic #2159

Procedure Codes

When submitting PA (prior authorization) requests and claims, home health providers should use HCPCS (Healthcare Common Procedure Coding System) procedure codes. Providers should refer to the DME (Durable Medical Equipment) Index for a list of valid procedure codes for DME. Providers should refer to the DMS (Disposable Medical Supply) Index for a list of valid procedure codes for DMS.

Home health agencies providing PDN (private duty nursing) services to ventilator-dependent members should use CPT (Current Procedural Terminology) procedure codes on PA requests and claims.

Topic #2158

Revenue Codes

Providers are required to use a revenue code when submitting claims to ForwardHealth. The following table contains a list of revenue code examples. Providers should use the appropriate revenue code that best describes the service performed.

For the most current and complete list of revenue codes, contact the AHA NUBC (American Hospital Association National Uniform Billing Committee) by calling 312-422-3390 or writing to the following address:

American Hospital Association National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606

For further information, refer to the NUBC website.

Revenue Code	Service Description
0550	General Skilled Nursing
0551	Skilled Nursing Visit
0552	Skilled Nursing Hourly Charge
0580	Other Home Health Services, Except Therapies
0420	Physical Therapy
0430	Occupational Therapy
0440	Speech and Language Pathology

Topic #2157

Units of Service

The number of services (visits or hours) billed must be listed on each detail line of the claim form.

Home health aide visits, home health skilled nursing visits, and home health therapy visits are billed as one unit of service per day. If the quantity billed is not an increment of a whole unit, the service is denied.

Providers are required to bill their PDN (private duty nursing) services in six-minute increments according to the conversion chart for billing PDN services. Services must be recorded as one tenth (0.1) of a unit. One unit equals one hour. Reimbursement is not available for less than six minutes of service. For example, a provider who works for seven hours and 55 minutes would bill 7.9 units.

Conversion Chart for Billing Private Duty Nursing Services

Time Worked in Minutes	=	Billable Units (Hours)
≥ 0 & < 6	=	0
≥ 6 & < 12	=	0.1
≥ 12 & < 18	=	0.2
≥ 18 & < 24	=	0.3
≥ 24 & < 30	=	0.4
≥ 30 & < 36	=	0.5
≥ 36 & < 42	=	0.6
≥ 42 & < 48	=	0.7
≥ 48 & < 54	=	0.8
≥ 54 & < 60	=	0.9
≥ 60 & < 66	=	1
≥ 66 & < 72	=	1.1
≥ 72 & < 78	=	1.2
≥ 78 & < 84	=	1.3
≥ 84 & < 90	=	1.4
≥ 90 & < 96	=	1.5
≥ 96 & < 102	=	1.6
≥ 102 & < 108	=	1.7
≥ 108 & < 114	=	1.8
≥ 114 & < 120	=	1.9
≥ 120 & < 126	=	2
≥ 126 & < 132	=	2.1
≥ 132 & < 138	=	2.2
≥ 138 & < 144	=	2.3
≥ 144 & < 150	=	2.4
≥ 150 & < 156	=	2.5
≥ 156 & < 162	=	2.6
≥ 162 & < 168	=	2.7
≥ 168 & < 174	=	2.8
≥ 174 & < 180	=	2.9
≥ 180 & < 186	=	3

Time Worked in Minutes	=	Billable Units (Hours)
≥ 186 & < 192	=	3.1
≥ 192 & < 198	=	3.2
≥ 198 & < 204	=	3.3
≥ 204 & < 210	=	3.4
≥ 210 & < 216	=	3.5
≥ 216 & < 222	=	3.6
≥ 222 & < 228	=	3.7
≥ 228 & < 234	=	3.8
≥ 234 & < 240	=	3.9
≥ 240 & < 246	=	4
≥ 246 & < 252	=	4.1
≥ 252 & < 258	=	4.2
≥ 258 & < 264	=	4.3
≥ 264 & < 270	=	4.4
≥ 270 & < 276	=	4.5
≥ 276 & < 282	=	4.6
≥ 282 & < 288	=	4.7
≥ 288 & < 294	=	4.8
≥ 294 & < 300	=	4.9
≥ 300 & < 306	=	5
≥ 306 & < 312	=	5.1
≥ 312 & < 318	=	5.2
≥ 318 & < 324	=	5.3
≥ 324 & < 330	=	5.4
≥ 330 & < 336	=	5.5
≥ 336 & < 342	=	5.6
≥ 342 & < 348	=	5.7
≥ 348 & < 354	=	5.8
≥ 354 & < 360	=	5.9
≥ 360 & < 366	=	6

Time Worked in	Billable

Time Worked in	Billable

Time Worked in Minutes					=	Units (Hours)
≥	366	&	<	372	=	6.1
≥	372	&	<	378	=	6.2
≥	378	&	<	384	=	6.3
≥	384	&	<	390	=	6.4
≥	390	&	<	396	=	6.5
≥	396	&	<	402	=	6.6
≥	402	&	<	408	=	6.7
≥	408	&	<	414	=	6.8
≥	414	&	<	420	=	6.9
≥	420	&	<	426	=	7
≥	426	&	<	432	=	7.1
≥	432	&	<	438	=	7.2
≥	438	&	<	444	=	7.3
≥	444	&	<	450	=	7.4
≥	450	&	<	456	=	7.5
≥	456	&	<	462	=	7.6
≥	462	&	<	468	=	7.7
≥	468	&	<	474	=	7.8
≥	474	&	<	480	=	7.9
≥	480	&	<	486	=	8
≥	486	&	<	492	=	8.1
≥	492	&	<	498	=	8.2
≥	498	&	<	504	=	8.3
≥	504	&	<	510	=	8.4
≥	510	&	<	516	=	8.5
≥	516	&	<	522	=	8.6
≥	522	&	<	528	=	8.7
≥	528	&	<	534	=	8.8
≥	534	&	<	540	=	8.9
≥	540	&	<	546	=	9

Time Worked in Minutes					=	Units (Hours)
≥	546	&	<	552	=	9.1
≥	552	&	<	558	=	9.2
≥	558	&	<	564	=	9.3
≥	564	&	<	570	=	9.4
≥	570	&	<	576	=	9.5
≥	576	&	<	582	=	9.6
≥	582	&	<	588	=	9.7
≥	588	&	<	594	=	9.8
≥	594	&	<	600	=	9.9
≥	600	&	<	606	=	10
≥	606	&	<	612	=	10.1
≥	612	&	<	618	=	10.2
≥	618	&	<	624	=	10.3
≥	624	&	<	630	=	10.4
≥	630	&	<	636	=	10.5
≥	636	&	<	642	=	10.6
≥	642	&	<	648	=	10.7
≥	648	&	<	654	=	10.8
≥	654	&	<	660	=	10.9
≥	660	&	<	666	=	11
≥	666	&	<	672	=	11.1
≥	672	&	<	678	=	11.2
≥	678	&	<	684	=	11.3
≥	684	&	<	690	=	11.4
≥	690	&	<	696	=	11.5
≥	696	&	<	702	=	11.6
≥	702	&	<	708	=	11.7
≥	708	&	<	714	=	11.8
≥	714	&	<	720	=	11.9
≥	720	&	<	726	=	12

Topic #643

Unlisted Procedure Codes

According to the HCPCS (Healthcare Common Procedure Coding System) codebook, if a service is provided that is not accurately described by other HCPCS CPT (Current Procedural Terminology) procedure codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC (not otherwise classified), procedure code, a provider should determine if there is another more specific code that could be indicated to describe the procedure or service being performed/provided. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA (prior authorization) request, to justify use of the unlisted procedure code and to describe the procedure or service rendered. Submitting the proper documentation, which could include a PA request, may result in more timely claims processing.

Unlisted procedure codes should not be used to request adjusted reimbursement for a procedure for which there is a more specific code available.

Unlisted Codes That Do Not Require Prior Authorization or Additional Supporting Documentation

For a limited group of unlisted procedure codes, ForwardHealth has established specific policies for their use and associated reimbursement. These codes do not require PA or additional documentation to be submitted with the claim. Providers should refer to their service-specific area of the Online Handbook on the ForwardHealth Portal for details about these unlisted codes.

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

Certain unlisted procedure codes require PA. Providers should follow their service-specific PA instructions and documentation requirements for requesting PA. For a list of procedure codes for which ForwardHealth requires PA, refer to the service-specific interactive maximum allowable fee schedule.

In addition to a properly completed PA request, documentation submitted on the service-specific PA attachment or as additional supporting documentation with the PA request should provide the following information:

- Specifically identify or describe the name of the procedure/service being performed or billed under the unlisted code.
- List/justify why other codes are not appropriate.
- Include only relevant documentation.
- Include all required clinical/supporting documentation.

For most situations, once the provider has an approved PA request for the unlisted procedure code, there is no need to submit additional documentation along with the claim.

Unlisted Codes That Do Not Require Prior Authorization

If an unlisted procedure code does not require PA, documentation submitted with the claim to justify use of the unlisted code and to describe the procedure/service rendered must be sufficient to allow ForwardHealth to determine the nature and scope of the procedure and to determine whether or not the procedure is covered and was medically necessary, as defined in Wisconsin Administrative Code.

The documentation submitted should provide the following information related to the unlisted code:

- Specifically identify or describe the name of the procedure/service being performed or billed under the unlisted code.
- List/justify why other codes are not appropriate.
- Include only relevant documentation.

How to Submit Claims and Related Documentation

Claims including an unlisted procedure code and supporting documentation may be submitted to ForwardHealth in the following ways:

- If submitting on paper using the 1500 Health Insurance Claim Form ((02/12)), the provider may do either of the following:
  - Include supporting information/description in Item Number 19 of the claim form.
  - Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate See Attachment in Item Number 19 of the claim form and send the supporting documentation along with the claim form.
- If submitting electronically using DDE (Direct Data Entry) on the Portal, PES (Provider Electronic Solutions) software, or

837 (837 Health Care Claim) electronic transactions, the provider may do one of the following:

- Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.
- Indicate that supporting documentation will be submitted separately on paper. This option should be used if the Notes field does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate See Attachment in the Notes field of the electronic transaction and submit the supporting documentation on paper.
- Upload claim attachments via the secure Provider area of the Portal.

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, HIPPS (Health Insurance Prospective Payment System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

Code Validity

In order for a code to be valid, it must reflect the highest number of required characters as indicated by its national coding and billing manual. If a stakeholder uses a code that is not valid, ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid code.

Code Specificity for Diagnosis

All codes allow a high level of detail for a condition. The level of detail for ICD (International Classification of Diseases) diagnosis codes is expressed as the level of specificity. In order for a code to be valid, it must reflect the highest level of specificity (contain the highest number of characters) required by the code set. For some codes, this could be as few as three characters. If a stakeholder uses an ICD diagnosis code that is not valid (not to the specific number of characters required), ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid ICD diagnosis code.

Covered Services and Requirements

Topic #2156

An Overview of Covered Services

Home health agencies may request provider enrollment to bill ForwardHealth for the following covered services:

- Home health skilled nursing services
- Home health aide services
- PDN (private duty nursing) services
- Home health therapy services
- DME (durable medical equipment)
- DMS (disposable medical supplies)
- Personal care services

Topic #24343

BadgerCare Plus Postpartum Program Coverage

Pregnant members enrolled in BadgerCare Plus keep their health care coverage for 12 months after the end of their pregnancy, per 2025 Wisconsin Act 102. These members are eligible for all covered services during this postpartum period as part of their care.

Eligibility

Most full-benefit BadgerCare Plus or Medicaid members enrolled on their last day of pregnancy are eligible for an estimated 365 days of postpartum BadgerCare Plus coverage (The window of coverage occurs for 365 days through the end of the month in which the 365th day falls. For example, if the end of a qualifying member's pregnancy occurred on April 14, 2026, their postpartum coverage period would be complete on April 30, 2027).

If someone is already enrolled in BadgerCare Plus or Medicaid but does not report a pregnancy until after it has ended, they may still qualify for postpartum coverage, but they must be enrolled in the month in which the pregnancy ended.

If someone applies for coverage after their pregnancy has ended, they are eligible for 12-months of postpartum coverage if they obtain retroactive coverage for the month in which the pregnancy ended.

Exceptions

Members will not qualify for the 12-month BadgerCare Plus postpartum coverage period if any of these statements are true:

- They were enrolled in the BadgerCare Prenatal Program.
- They were only enrolled in BadgerCare through presumptive eligibility, also known as Express Enrollment.
- Their pregnancy ended before January 1, 2026.

Circumstances when coverage may end

The 12-month postpartum coverage period can end prior to the 12 months only if the member:

- Gained eligibility based on incorrect information or agency error.
- Asks to disenrolled from coverage.
- Moves outside of Wisconsin.
- Dies.

Topic #2155

Case Sharing

If more than one Medicaid-enrolled home care provider provides care to a member, the case becomes a shared case. All NIPs (nurses in independent practice) sharing a case with personal care agencies or home health agencies should document their communication with the other providers regarding member needs, POC (plan of care), and scheduling. This will ensure coordination of services and continuity of care, while also preventing duplication of services being provided to a member.

According to Wis. Admin. Code § DHS 101.03(96m)(b)6., medically necessary services cannot be duplicative with respect to other services being provided to the member. When providers of more than one service type share a case, providers need to integrate the other service information into the member's POC. This information must be included regardless of the payer source for services of other providers on a shared case.

The POC must include the names of other providers if the case is shared. The PA/CPA completion instructions (Prior Authorization/Care Plan Attachment instructions, F-11096A (08/15)) require the names of the PDN (private duty nurse), personal care, and home health providers sharing the case to be included in Element 23. The POC must contain no less information than is required for the PA/CPA. The names, not the license number or NPI (National Provider Identifier), of the other Medicaid-enrolled providers on the case are required.

Topic #44

Definition of Covered Services

A covered service is a service, item, or supply for which reimbursement is available when **all** program requirements are met. Wis. Admin. Code § DHS 101.03(35) and ch. DHS 107 contain more information about covered services.

Topic #2154

Disposable Medical Supplies Included in the Home Care Reimbursement Rate

DMS (disposable medical supplies) are medically necessary items that have a limited life expectancy and are consumable, expendable, disposable, or nondurable.

The cost of routine DMS used by home health providers, personal care providers, and NIP (nurses in independent practice) while caring for the member, including routine DMS mandated by OSHA (Occupational Safety and Health Administration), is covered in the reimbursement rate for the service provided. Home health providers, personal care providers, and NIP are expected to provide these supplies only during the billable hours in which they provide covered services. Providers are not expected to provide members with supplies for use when they are not directly providing covered services.

Note: None of the DMS covered in the reimbursement rate are separately reimbursable.

When DMS is included in the reimbursement rate, providers may **not** do any of the following:

- Charge the member for the cost of DMS.
- Use supplies obtained by the member and paid for by Wisconsin Medicaid.
- Submit claims to ForwardHealth for the cost of the supplies.

DMS included in the home care reimbursement rate include, but are not limited to, those listed in the following table.

Procedure Code	Modifier	Description
A4244	—	Alcohol or peroxide, per pint
A4402	—	Lubricant per ounce
A4455	—	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce
A4456	—	Adhesive remover, wipes, any type, each
A4927	—	Gloves, non-sterile, per 100

Topic #2153

Durable Medical Equipment

DME (durable medical equipment) is equipment that can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in any setting in which normal life activities take place.

Medicaid Home Health Final Rule (CMS-2348-F) requires a prescribing provider to write the initial prescription for certain DME as defined by CMS (Centers for Medicare & Medicaid Services). The list of impacted DME is maintained by CMS and providers should regularly check it for changes. Covered services are limited to items contained in the DME Index. Some items require PA (prior authorization). For further information, refer to the DME service area.Topic #85

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in Wis. Admin. Code § DHS 101.03(52), as those services that are necessary to prevent the death or serious impairment of the health of the individual. Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- PA (prior authorization) or other program requirements may be waived in emergency situations.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Topic #20977

Face-to-Face Visit Requirements

A member is required to have a face-to-face visit with a physician or authorized NPP (non-physician practitioner) for the initial

prescription of home health nursing services, home health aide services, and home health therapies (OT (occupation therapy), PT (physical therapy), SLP (speech-language pathology)).

The following NPPs are allowed to provide the face-to-face visit:

- Clinical nurse specialist
- Nurse midwife
- Nurse practitioner
- Physician assistant

The face-to-face visit must occur no more than 90 days before or 30 days after the start of services for initial ordering.

Physicians are required to document the face-to-face visit with a member for the initial prescription of home health services.

If the prescribing physician does not perform the face-to-face visit for home health services personally, the practitioner who performed the face-to-face visit must communicate the clinical findings of the face-to-face visit to the prescribing physician. The prescribing physician has discretion on the type of communication they will accept from the practitioner who completed the actual face-to-face visit.

For services that require PA (prior authorization), providers are required to include the initial physician prescription and physician documentation of the face-to-face visit in the PA request. If the service does not require PA, providers are still required to maintain the original physician prescription and documentation of a face-to-face visit in the member's medical record.

Note: For an initial prescription, a physician or qualified healthcare professional can meet the face-to-face requirement by providing functionally equivalent synchronous audio-visual telehealth.

Second Face-to-Face Visit Not Required

If an individual has a documented face-to-face visit with a physician or NPP for the initial prescription of home health or impacted DME (durable medical equipment) and DMS (disposable medical supplies), and the individual subsequently enrolls in Wisconsin Medicaid, a new face-to-face visit is not required.

Providers are required to maintain the original physician prescription and documentation of a face-to-face visit in the member's medical record and submit them with the PA request if a PA is applicable.

Topic #22917

Interpretive Services

ForwardHealth reimburses interpretive services provided to BadgerCare Plus and Medicaid members who are deaf or hard of hearing or who have LEP (limited English proficiency). A member with LEP is someone who does not speak English as their primary language and who has a limited ability to read, speak, write, or understand English.

Interpretive services are defined as the provision of spoken or signed language communication by an interpreter to convey a message from the language of the original speaker into the language of the listener in real time (synchronous) with the member present. This task requires the language interpreter to reflect both the tone and the meaning of the message.

Only services provided by interpreters of the spoken word or sign language will be covered with the HCPCS (Healthcare Common Procedure Coding System) procedure code T1013 (Sign language or oral interpretive services, per 15 minutes). Translation services for written language are not reimbursable with T1013, including services provided by professionals trained to interpret written text.

Covered Interpretive Services

ForwardHealth covers interpretive services for deaf or hard of hearing members or members with LEP when the interpretive service and the medical service are provided to the member on the same DOS (date of service) and during the same time as the medical service. A Medicaid-enrolled provider must submit for interpretive services on the same claim as the medical service, and the DOS they are provided to the member must match. Interpretive services cannot be billed by HMOs and MCOs (managed care organizations). Providers should follow CPT (Current Procedural Terminology) and HCPCS coding guidance to appropriately document and report procedure codes related to interpretive and medical services on the applicable claim form. Time billed for interpretive services should reflect time spent providing interpretation to the member. At least three people must be present for the services to be covered: the provider, the member, and the interpreter.

Interpreters may provide services either in-person or via telehealth. Services provided via telehealth must be functionally equivalent to an in-person visit, meaning that the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Billing time for documentation of interpretive services will be considered part of the service performed. BadgerCare Plus and Wisconsin Medicaid have adopted the federal "Documentation Guidelines for Evaluation and Management Services" (CMS (Centers for Medicare & Medicaid Services) 2021 and 2023) in combination with BadgerCare Plus and Medicaid policy for E&M (evaluation and management) Services.

Most Medicaid-enrolled providers, including border-status or out-of-state providers, are able to submit claims for interpretive services.

Standard ForwardHealth policy applies to the reimbursement for interpretive services for out-of-state providers, including PA (prior authorization) requirements.

Interpretive Services Provided Via Telehealth for Out-of-State Providers

ForwardHealth requirements for services provided via telehealth by out-of-state providers are the same as the ForwardHealth policy for services provided in-person by out-of-state providers. Requirements for out-of-state providers for interpretive services are the same whether the service is provided via telehealth or in-person. Out-of-state providers who are not enrolled as either border-status or telehealth-only border-status providers are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members. The PA would indicate that interpretive services are needed.

Documentation

While not required for submitting a claim for interpretive services, providers must include the following information in the member's file:

- The interpreter's name and/or company
- The date and time of interpretation
- The duration of the interpretive service (time in and time out or total duration)
- The amount submitted by the medical provider for interpretive services reimbursement
- The type of interpretive service provided (foreign language or sign language)
- The type of covered service(s) the provider is billing for

Third-Party Vendors and In-House Interpreters

Providers may be reimbursed for the use of third-party vendors or in-house interpreters supplying interpretive services.

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements

apply to interpretive services. When a covered entity or provider utilizes interpretive services that involve PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate measures for their situation.

Limitations

There are no limitations for how often members may utilize interpretive services when the interpretive service is tied to another billable medical service for the member for the same DOS.

Claims Submission

To receive reimbursement, providers may bill for interpretive services on one of the following claim forms:

- 1500 Health Insurance Claim Form ((02/12)) (for dental, professional, and professional crossover claims)
- Institutional UB-04 (CMS 1450) claim form (for outpatient crossover claims and home health/personal care claims)

Noncovered Services

The following will not be eligible for reimbursement with procedure code T1013:

- Interpretive services provided in conjunction with a noncovered, non-reimbursable, or excluded service
- Interpretive services provided by the member's family member, such as a parent, spouse, sibling, or child
- The interpreter's waiting time and transportation costs, including travel time and mileage reimbursement, for interpreters to get to or from appointments
- The technology and equipment needed to conduct interpretive services
- Interpretive services provided directly by the HMOs and MCOs are not billable to ForwardHealth for reimbursement via procedure code T1013

Cancellations or No Shows

Providers cannot submit a claim for interpretive services if an appointment is cancelled, the member or the interpreter is a no-show (is not present), or the interpreter is unable to perform the interpretation needed to complete the appointment successfully.

Procedure Code and Modifiers

Providers must submit claims for interpretive services and the medical service provided to the member on separate details on the same claim.

Procedure code T1013 is a time-based code, with 15-minute increments. Rounding up to the 15-minute mark is allowable if at least eight minutes of interpretation were provided.

Providers should use the following rounding guidelines for procedure code T1013.

Time (Minutes)	Number of Interpretation Units Billed
8–22 minutes	1.0 unit
23–37 minutes	2.0 units
38–52 minutes	3.0 units
53–67 minutes	4.0 units
68–82 minutes	5.0 units

83–97 minutes	6.0 units

Claims for interpretive services must include HCPCS procedure code T1013 and the appropriate modifier(s):

- U1 (Spoken language)
- U3 (Sign Language)
- GT (Via interactive audio and video telecommunication systems)
- 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)

Providers should refer to the interactive maximum allowable fee schedules for the reimbursement rate, covered provider types and specialties, modifiers, and the allowable POS (place of service) codes for procedure code T1013.

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters		Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
Telehealth* (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		U1 or U3 **and** GT or 93
	Phone (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 **and** 93
	Interactive video (foreign language and sign language)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 **and** GT

*Any telehealth service must be provided using HIPAA-compliant software or delivered via an app or service that includes all the necessary privacy and security safeguards to meet the requirements of HIPAA.

Dental Providers

Dental providers submitting claims for interpretive services are not required to include a modifier with procedure code T1013. Dental providers should retain documentation of the interpretive service in the member's records.

Allowable Places of Service

Claims for interpretive services must include a valid POS (place of service) code where the interpretive services are being provided.

Federally Qualified Health Centers

Non-Tribal FQHCs (federally qualified health centers), also known as CHCs (community health centers), and Tribal FQHCs

(POS codes 50 and XX), will not receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the bundled PPS (prospective payment system) (or AIR (all-inclusive rate) for Tribal FQHCs) rate. However, CHCs and Tribal FQHCs can still bill the T1013 code as an indirect procedure code when providing interpretive services. This billing process is similar to that of other indirect services provided by non-Tribal FQHCs. This will enable Wisconsin DHS (Department of Health Services) to better track how CHCs and Tribal FQHCs provide these services and process any future change in scope adjustment to increase their PPS rate that includes providing interpretive services.

Rural Health Clinics

RHCs (rural health clinics) (POS code 72) receives direct reimbursement for interpretive services. Procedure code T1013 should be billed when providing interpretive services.

Interpreter Qualifications

The two types of allowable interpreters include:

- Sign language interpreters—Professionals who facilitate the communication between a hearing individual and a person who is deaf or hard of hearing and uses sign language to communicate
- Foreign language interpreters—Professionals who are fluent in both English and another language and listen to a communication in one language and convert it to another language while retaining the same meaning

Qualifications for Sign Language Interpreters

For Medicaid-enrolled providers to receive reimbursement, sign language interpreters must be licensed in Wisconsin under Wis. Stat. § 440.032 and must follow the specific requirements regarding education, training, and locations where they are able to interpret. The billing provider is responsible for determining the sign language interpreter's licensure and must retain all documentation supporting it.

Qualifications for Foreign Language Interpreters

There is not a licensing process in Wisconsin for foreign language interpreters. However, Wisconsin Medicaid strongly recommends that providers work through professional agencies that can verify the qualifications and skills of their foreign language interpreters.

A competent foreign language interpreter should:

- Be at least 18 years of age.
- Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using necessary specialized vocabulary.
- Demonstrate proficiency in English and another language and have knowledge of the relevant specialized terms and concepts in both languages.
- Be guided by the standards developed by the National Council on Interpreting Health Care.
- Demonstrate cultural responsiveness regarding the LEP language group being served including values, beliefs, practices, languages, and terminology.

Topic #2089

Medical Necessity

Wisconsin Medicaid reimburses enrolled home health agencies for medically necessary home health services as defined by Wis. Admin. Code § DHS 101.03(96m), provided to eligible members when prescribed by a physician. All services are required to be

medically necessary and appropriate to the diagnosis and medical condition of the member. Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Topic #86

Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA (prior authorization) was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid enrollment.

Topic #2088

Place of Service

Members who are authorized to receive home health services in the home may make use of approved hours of service outside the home setting during those hours when a member's normal life activities take them outside the home setting.

Hospital inpatient and nursing facilities are not allowable POS (places of service) while the member is receiving home health services.

Home health services may be provided in a CBRF (community based residential facility); however, the services may not exceed the limits established in Wis. Admin. Code ch. DHS 83, and may not duplicate services that the CBRF is being paid to provide.

Topic #1097

Private Duty Nursing Reimbursement

For PDN (private duty nursing) services to be reimbursed, the services must be covered and meet the following requirements:

- ForwardHealth's criteria to be classified as PDN services.
- Are prior authorized.
- Are prescribed by a physician in accordance with Wis. Stat. § 49.46(2).
- Are provided to member enrolled under Wis. Stat. § 49.47(6)(a).
- Are implemented according to Wis. Admin. Code ch. DHS 107.
- Are provided in accordance with the member's POC (plan of care). Services provided to the member that are not listed on the POC are not covered services.

Topic #66

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including—but not limited to—medical necessity, PA (prior authorization), claims submission, prescription, and documentation requirements.

Topic #2152

Services Provided by Nurses in Independent Practice

Federal and state laws permit Wisconsin Medicaid to pay for home health skilled nursing services provided by an NIP (nurse in independent practice) **only** when no home health agency is available. An NIP is required to have PA (prior authorization) before providing home health services to a member.

The following conditions **must** be met before an NIP can submit claims to ForwardHealth for home health services:

- No home health agency is willing and able to provide care to the member. If an NIP submits claims to ForwardHealth, that nurse is required to submit documentation supporting this condition with the PA request. The NIP, the member, the member's family, or a discharge planner is first required to try to locate services by contacting **all** home health agencies serving the member's area. Documentation must include the following:
  - The name of each home health agency contacted
  - The name of the person contacted at the home health agency
  - The date and time of contact
  - Information the caller provided to the home health agency contact
  - A list of the questions the caller asked the home health agency contact
  - The responses the home health agency contact gave to the caller's questions
- The services must be medically necessary.
- Member requires a considerable and taxing effort to leave the residence or the member cannot reasonably obtain these services outside the residence or from a more appropriate provider.
- All rules in Wis. Admin. Code chs. DHS 101–109 must be followed. Home health services provided by an NIP are monitored after payment has been made. Payment for services that do not follow these guidelines will be recouped.

Topic #824

Services That Do Not Meet Program Requirements

As stated in Wis. Admin. Code § DHS 107.02(2), BadgerCare Plus and Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained
- Services for which the provider fails to meet any or all of the requirements of Wis. Admin. Code § DHS 106.03, including, but not limited to, the requirements regarding timely submission of claims
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations
- Services that Wisconsin DHS (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration
- Services provided by a provider who fails or refuses to meet and maintain any of the enrollment requirements under Wis. Admin. Code ch. DHS 105
- Services provided by a provider who fails or refuses to provide access to records
- Services provided inconsistent with an intermediate sanction or sanctions imposed by DHS

Topic #3367

Training Requirements

Home health agency providers will only be reimbursed for covered services provided by agency staff who are properly trained, as indicated by licensure, certification, or other documentation of training in the provider's personnel file.

Topic #2087

Universal Precautions

All caregivers providing services are required to follow universal precautions for each member for whom services are provided. It is recommended that all caregivers are required to have the necessary orientation, education, and training in the epidemiology, modes of transmission, and prevention of transmissible infections.

HealthCheck Other Services

Topic #22

Definition of HealthCheck Other Services

HealthCheck is the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. The HealthCheck benefit provides periodic, comprehensive health screening exams (also known as well child checks), as well as interperiodic screens, outreach and case management, and additional medically necessary services (referred to as HealthCheck Other Services) for members under 21 years of age.

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck Other Services is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid, per Wis. Admin. Code § DHS 107.02(3)(e). Most HealthCheck Other Services require PA (prior authorization) per Wis. Admin. Code § DHS 107.02.

Topic #1

Prior Authorization for HealthCheck Other Services

Providers submitting PA (prior authorization) requests for HealthCheck Other Services should review the two types of PA requests. The following types of PA requests have their own submission requirements:

- Requests for exceptions to coverage limitations
- Requests for federally allowable Medicaid services not routinely covered by Wisconsin Medicaid

PA Submission Requirements for Exceptions to Coverage Limitations

HealthCheck Other Services may additionally cover established Medicaid health care services that are limited in coverage for members under 21 years of age.

If a PA request is submitted requesting additional coverage for a benefit where there is established policy, the request is automatically processed under the HealthCheck Other Services benefit to evaluate whether the requested service is likely to correct or ameliorate the member's condition, including maintaining current status or preventing regression.

Examples of coverage limitations include service amounts that are prohibited by policy, or the requested service is not expected to result in a favorable improvement in the member's condition or diagnosis.

Every PA request for a member under age 21 is first processed according to standard Medicaid guidelines and then reviewed under HealthCheck Other Services guidelines. For these reasons, providers do **not** need to take additional action to identify the PA request as a HealthCheck Other Services request.

If an established benefit will be requested at a level that exceeds Wisconsin Medicaid coverage limits, in addition to the required PA documentation detailed in the appropriate service area of the Online Handbook, the request should provide:

- The rationale detailing why standard coverage is not considered acceptable to address the identified condition.
- The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

PA Submission Requirements for Services Not Routinely Covered by Wisconsin Medicaid

HealthCheck Other Services allows coverage of health care services that are not routinely covered by Wisconsin Medicaid, but are federally allowable and medically necessary to maintain, improve, or correct the member's physical and mental health, per § 1905(a) of the Social Security Act. These HealthCheck Other Services require PA since the determination of medical necessity is made on a case-by-case basis depending on the needs of the member.

If a PA request is submitted requesting coverage for a service that does not have established policy and is not an exception to coverage limitations, the provider is required to identify the PA as a HealthCheck Other Services request by **checking the HealthCheck Other Services box** and submit the following information:

- A current, valid order or prescription for the service being requested:
  - Prescriptions are valid for 12 or fewer months from the date of the signature (depending on the service area).
  - Updated prescriptions may be required more frequently for some benefits.
- A completed PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), for most service areas, including the following:
  - For Element 1, **check the HealthCheck Other Services box.**
  - For Element 19, enter the procedure code that most accurately describes the service, even if the code is not ordinarily covered by Wisconsin Medicaid. Unlisted procedure codes can be requested if the service is not accurately described by existing procedure codes.
  - For Element 20, enter informational procedure code modifier EP (Service provided as part of Medicaid early periodic screening diagnosis and treatment [EPSDT] program) to indicate that the service is requested as a HealthCheck Other Services benefit.
  - For Element 22, include the description of the service.
- A completed PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)).
- A PA attachment form(s) for the related service area, if known, or clinical documentation substantiating the medical necessity of the requested procedure code and:
  - The rationale detailing why services typically covered by Wisconsin Medicaid are not considered acceptable to address the identified condition or why services were discontinued.
  - The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

  Note: Providers may call Provider Services to determine the appropriate PA attachment.

- Evidence the requested service is clinically effective and not harmful (If the requested service is new to Wisconsin Medicaid, additional documentation regarding current research and/or safety of the intervention may be submitted.)
- The MSRP (manufacturer's suggested retail price) for requested equipment or supplies
- The 11-digit NDC (National Drug Code) for any requested OTC (over-the-counter) drugs on pharmacy PA requests

Providers may call Provider Services for more information about HealthCheck Other Services.

If the PA request is incomplete or additional information is needed to substantiate the necessity of the requested service, the PA request will be returned to the provider. **A return for more information is not a denial.**

Topic #41

Requirements

For a service to be reimbursed through HealthCheck Other Services, the following requirements must be met:

- The service is provided to a member who is under 21 years of age.
- The service is coverable under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently available are not considered acceptable to treat the identified condition.

ForwardHealth has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as the authorized amount is reasonable and maintains the preventive intent of the HealthCheck benefit.

HealthCheck Other Services does not include reimbursement in excess of ForwardHealth published maximum allowable fees.

All PA (prior authorization) requests must follow NCCI (National Correct Coding Initiative) guidelines.

Home Health Aide Services

Topic #2125

Active Seizure Intervention

Active seizure intervention, including safety measures, reporting seizures, and administration of medication at the time of the active seizure, may be a delegated nursing act. Active seizure intervention may be medically necessary when the member has had active seizures requiring active intervention within the past 62 days. Active seizure intervention does not include administration of routine anti-seizure medication. When observation for seizures is the only service performed, it is not a Medicaid-reimbursed service.

Topic #2124

Activity of Daily Living Tasks

Assistance with the member's ADLs (activities of daily living) as listed in Wis. Admin. Code § DHS 107.11(2)(b)2, is considered a home health aide service only when provided in conjunction with a delegated nursing act that cannot be safely delegated to a PCW (personal care worker) as determined and documented by the delegating RN (registered nurse). ADL tasks are not generally provided to preschool children but may be covered when the tasks require special skills to assure safety or are provided incidental to a delegated nursing act.

Topic #2123

Assistance with Activities That Are Directly Supportive of Skilled Therapy Services

Assistance with activities that directly support skilled therapy services include those activities that do not require the skills of a therapy provider to be safely and effectively performed. Activities may include routine maintenance exercises (for example, range of motion exercises and repetitive speech routines). In order to be medically necessary, the activities must be ordered in conjunction with an active home health therapy program or as the direct result of a therapy evaluation completed and signed by a therapy provider within the past six months.

Topic #2122

Complex Feeding

Complex feeding may be a delegated nursing act and medically necessary when there is a potential for aspiration and the physician's orders indicate special feeding precautions or techniques must be utilized to effect safe feeding.

Feeding via a gastrostomy tube may be a delegated nursing act when delegated by the RN (registered nurse) after assessment of the member's medical condition and the home health aide's training.

Topic #2121

Complex Repositioning

Complex repositioning is positioning to reduce spasticity or to decrease pressure and/or shear forces that can lead to decubitus ulcer formation (for example, Bolsters/Side-Lyers). Complex repositioning may be medically necessary when the member has a demonstrated problem with frequent skin breakdown.

Topic #2120

Complex Transfers

Complex transfers are transfers that require the use of mechanical devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly or when a complex transfer technique is used as part of a home health therapy program.

The following transfer techniques are part of the suggested personal care curriculum and **do not qualify as complex transfers**:

- Standing-pivot
- Sliding board
- Gait belts

Complex transfers may be medically necessary when the member has no volitional movement or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

Topic #2119

Definition

Home health aide services are services necessary to maintain the member's health or to facilitate treatment of the member's medical condition. There are three components to the services home health aides may provide in the home:

- Delegated nursing acts
- ADL (activity of daily living) tasks
- Household tasks

For activities of daily living and/or household tasks incidental to direct care activities to be covered when provided by a home health aide, the home health aide must provide at least one RN- (registered nurse)delegated medically oriented task with each home health aide visit (Wis. Admin. Code § DHS 107.11[1][b]). When no RN-delegated medically oriented task is to be provided, the activities might be covered as a personal care service. For more information regarding coverage of personal care services, refer to the Personal Care area of the Online Handbook.

Topic #2118

Delegated Nursing Acts

Delegated nursing acts are those medically necessary tasks that require some special medical knowledge or skill. Delegated nursing acts are usually reimbursed for minor children. Delegated nursing acts that may be safely delegated by an RN (registered nurse) may be reimbursable home health aide services. Delegated nursing acts include:

- Medication administration

- Skin care
- Dressing changes
- Assistance with activities directly supportive of skilled therapy services
- Vital signs
- Glucometer readings
- Complex transfers
- Complex repositioning
- Complex feeding
- Donning or doffing of a prosthesis or orthosis
- Active seizure intervention

Topic #2117

Delegation of Tasks

Each home health aide task must be specifically assigned by an RN (registered nurse). The RN must determine that the home health aide is trained to perform each task in a manner that will not jeopardize the member's health. A home health aide may not be assigned to any task for which he or she is not trained.

Note: RNs may only delegate **nursing** acts to a home health aide. A **medical** act that has been delegated to an RN by a physician may not be re-delegated by the RN to any other provider.

In accordance with Wis. Admin. Code ch. N 6.03(3), an RN should do all of the following in the supervision and direction of delegated nursing acts:

- Delegate tasks commensurate with education preparation and demonstrated abilities of the person supervised.
- Provide direction and assistance to those supervised.
- Observe and monitor the activities of those supervised.
- Evaluate the effectiveness of acts performed under supervision.

Home health agencies must document that these conditions are met when nursing acts are delegated to home health aides.

Topic #2116

Donning and Doffing of a Prosthesis or an Orthosis

Donning or doffing of a prosthesis or orthosis may be a delegated nursing act and medically necessary when part of a serial splinting program or when the member has a demonstrated problem with frequent skin breakdown that must be closely monitored.

Topic #2115

Dressing Changes

Some dressing changes may not require the skills of a licensed nurse and may be safely performed by a home health aide. Wounds or ulcers that show redness, edema, or induration — at times with epidural blistering or desquamation — do not ordinarily require skilled nursing care. Dressing changes may be medically necessary when the physician orders them for the treatment of a wound or sore, and no primary caregiver is willing or able to provide the care.

Topic #2114

Glucometer Readings

Taking glucometer readings and reporting them to the supervising nurse whenever the readings are outside the parameters established for the member by the physician may be medically necessary when the member's medical history supports the need for ongoing monitoring for early detection of readings outside the established parameters. Glucometer readings related to the noncompliance of a competent adult do not justify glucometer tests as medically necessary tasks.

Topic #2113

Home Health Aide Visits

Within home health aide services, Wisconsin Medicaid reimburses for only two types of home health visits:

- **Home Health Aide Initial Visit**. The member's first home health aide visit in a calendar day. For BadgerCare Plus and Medicaid purposes, an initial visit may last up to four hours. Only one home health aide initial visit is reimbursable per calendar day per member, regardless of the number of providers.
- **Home Health Aide Subsequent Visit**. Each additional home health aide visit following the initial visit per calendar day. For BadgerCare Plus and Medicaid purposes, a home health aide subsequent visit may last up to three hours.

A visit begins when the home health aide enters the residence to provide a covered service. The visit ends when the home health aide leaves the residence.

Upon completion of the covered service, additional visits per day may be covered only when necessary. Additional visits must only be used to provide medically necessary time-specific tasks, tasks that could not feasibly be provided in one visit, or when the provider obtains PA (prior authorization) for continuous visits. Examples of time-specific tasks include:

- Helping the member in and out of bed using a Hoyer lift
- Scheduled G-tube feedings

Maximizing Visits

The time spent at home health aide visits must be maximized whenever possible before scheduling additional home health aide visits or personal care visits.

All cares that can be fulfilled utilizing the allotted four hours for an initial visit or the allotted three hours for a subsequent visit should be performed during that scheduled visit. Scheduling a subsequent visit or personal care visit later in the same day to complete cares that could have been completed during a previous visit that day would not be considered medically necessary because the previous visit was not maximized.

In addition, when case sharing with a personal care agency, home health aide visits must be maximized whenever possible before a PCW (personal care worker) begins providing care. The home health aide should perform all personal cares in addition to the delegated nursing acts during the visit.

Continuous Visits

All home health aide visits in excess of four hours must be prior authorized if the agency wishes to bill for more than one visit. These home health aide visits are referred to as continuous visits. Continuous visits may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to a member's medical condition. Immediate attention is classified as needing service within five minutes, leaving inadequate time for the member to call in a home health aide. The intervention must include a delegated nursing act.

When continuous visits of four or more hours are medically necessary, providers may bill for more than one visit when the visits have PA. Providers may not bill multiple visits for continuous home health aide visits without PA. Providers are required to request PA for continuous visits regardless of the 30-visit threshold.

Topic #2112

Household Tasks

When a home health aide visits a member to provide a delegated nursing act, the home health aide may also perform some household tasks. Provision of household tasks must be incidental to delegated nursing acts and personal care tasks and must not be the primary reason for the home health aide visit.

Household tasks are typically provided by parents for their minor children. Most household tasks provided to minor children are not covered. Incidental household tasks may be reimbursed only when the tasks are incidental to covered delegated nursing acts or covered ADL (activity of daily living) tasks.

Topic #2111

Medication Administration

"Administer" is defined in the Pharmacy Examining Board Act, Wis. Stat. § 450.01(1), as the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

Medication administration may be covered for an adult member when the member is unable to self-administer and there is no willing and able caregiver to administer the medication.

Parents typically administer medications to their minor children. However, medication administration may be reimbursed for minor children when the parents are unable to administer the medication. This includes times when parents are not allowed to leave work to administer medications and no other arrangements can be made.

General Agency Requirements Applicable to All Medication Administration by Home Health Aides

All home health agencies providing administration of a medication by a home health aide must meet the following conditions:

- The agency has policies and procedures designed to provide safe and accurate administration of medication. These policies must be followed by personnel assigned to administer medications (42 C.F.R. § 484.14[e]). This must include the required documentation of the name of the medication, the dose, the route of administration, the time of administration, and the identification of the person administering the medication.
- There is a written delegation of this nursing act (medication administration) by the RN (registered nurse) as specified in Wis. Admin. Code § DHS 133.17(3).
- There is documentation that gives evidence of the educational preparation of the caregiver who administers medications as stated in Wis. Admin. Code § DHS 133.06(4)(b).
- There is immediate and accessible supervisory support available to the caregiver administering medications as directed by Wis. Admin. Code § DHS 133.18(2).
- Members must be informed, prior to delivery of service, that their medications will be administered by unlicensed personnel as stated in Wis. Admin. Code § DHS 133.08(2)(d), and 42 C.F.R. § 484.10(c)(1).
- Supervision and direction of the delegated nursing act meets the requirements of Wis. Admin. Code § N 6.03(3), which states that in the supervision and direction of delegated nursing acts, an RN shall do the following:
  - Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.

- Provide direction and assistance to those supervised.
- Observe and monitor the activities of those supervised.
- Evaluate the effectiveness of acts performed under supervision.

Administration of Preselected Medication

A home health aide may administer medications to any member, regardless of age or functional capacity, when both of the following conditions are met:

- The medication is preselected by a nurse, pharmacist, member, or designated family member.
- All agency requirements are met.

Administration of Medication That Is Not Preselected

Administration of medication by home health aides may include selection of the medication and selection of the dose, along with direct application of the medication.

The act of administration of medication that has not been preselected may be provided by home health aides only when both of the following conditions are met and documented in the provider's records:

- When medication has not been preselected, there is documented evidence that the home health aide has been trained in the actions, uses, effects, adverse reactions, and toxic effects of all medications administered. Additionally, the home health aide must be trained relative to appropriate responses to adverse reactions to any medication administered. The delegating RN must verify the training by doing at least one return demonstration with each home health aide administering medication to a specific member as directed by Wis. Admin. Code § DHS 133.06(4)(c).
- All agency requirements are met.

Topic #2109

Providers of Services

Home health aides are required to be trained according to requirements issued by the DQA (Division of Quality Assurance). The completion of training and demonstration of competency to perform each assigned task should be documented in the home health aide's personnel record.

An RN (registered nurse), a physical therapist, an occupational therapist, or a speech-language pathologist is required to prepare written instructions for member services provided by a home health aide, as appropriate. Instructions may include duties, delegated nursing acts, a home therapy program, assistance with a member's activities of daily living, and household tasks incidental to direct care.

Topic #2108

Skin Care

Skin care may be a delegated nursing act and medically necessary when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Typically, a legend drug is a medication not sold over-the-counter. PRN (pro re nata) or prophylactic skin care is an ADL (activity of daily living) task, not a delegated nursing act.

Topic #2107

Vital Signs

Taking vital signs may include, but is not limited to, taking the following readings from the member:

- Temperature
- Blood pressure
- Pulse
- Pulse oximetry readings
- Respiratory rate

The member's vital signs are to be reported to the supervising nurse whenever they are outside the parameters established for the member by the physician. Taking vital signs may be medically necessary when the member's medical history supports the need for ongoing monitoring for early detection of an exacerbation, and the physician establishes parameters at which point a change in treatment may be required.

Home Health Skilled Nursing Services

Topic #2151

Catheters

Insertion and sterile irrigation and replacement of indwelling urinary catheters and care of suprapubic catheters are considered skilled nursing services. When the catheter is necessitated by a permanent or temporary loss of bladder control, medically necessary skilled nursing services that are provided at a frequency appropriate to the type of catheter in use are reimbursable.

When complications are absent, Foley catheters generally require skilled service once every 30 days and silicone catheters generally require skilled service once every 60–90 days. More frequent care may be reimbursed if documentation supports the medical necessity. This frequency of service is considered reasonable and medically necessary. In some instances, there are complications that require more frequent skilled services related to the catheter.

If intermittent catheterization is delegated to an LPN (licensed practical nurse) or home health aide by the RN (registered nurse), medical record documentation must support that the LPN or home health aide has been taught the procedure and has demonstrated competence in the procedure.

Topic #2150

Determining Skilled Nursing Services

In determining whether a service is skilled (requires the skills of an RN (registered nurse) or LPN (licensed practical nurse)), providers should consider the inherent complexity of the service, the condition of the member, and accepted standards of medical and nursing practice. Some services are classified as skilled nursing services on the basis of the complexity of the services alone, such as intravenous and intramuscular injections or insertion of catheters. However, the member's condition may be such that a service that would ordinarily be considered unskilled may be considered a skilled nursing service because the service can only be safely and effectively provided by a nurse.

Agencies should be aware that while some services may be provided by a licensed nurse, they may not be considered a Medicaid-covered service. For example, nonskilled services provided by a nurse due to the unavailability of a home health aide or PCW (personal care worker) to provide the nonskilled services, regardless of the importance of the services to the member, are not reimbursable as skilled nursing services.

Examples of Circumstances in Which Skilled Nursing May Be Required

There may be circumstances in which skilled nursing services may be required for services that might ordinarily be considered unskilled care. For example:

- A broken leg does not necessarily indicate a need for skilled care. However, if the member has a pre-existing circulatory condition, skilled nursing services may be needed to check for complications, to monitor medication administration for pain control, and to teach proper ambulation techniques to ensure proper bone alignment and healing.
- The condition of a member who has irritable bowel syndrome or who is recovering from rectal surgery may be such that only a nurse can safely and effectively give the member an enema. If the enema is necessary to treat the medical condition, the visit may be covered as a skilled nursing visit.

However, a service that, by its nature, requires the skills of a licensed nurse to be provided safely and effectively, continues to be

a skilled service even if it is taught to the member, the member's family, or other caregivers. For example, if a member is discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day, the care is considered skilled nursing care, even if the family is taught to perform the care and provides it part or all of the time.

Topic #2149

Home Health Skilled Nursing Visits

Wisconsin Medicaid reimburses only two types of home health skilled nursing visits:

- **Home Health Skilled Nursing Initial Visit** — the member's first home health skilled nursing visit of any duration by an RN (registered nurse) or LPN (licensed practical nurse) in a calendar day. Only one initial visit is reimbursable per calendar day per member, regardless of the number of providers.
- **Home Health Skilled Nursing Subsequent Visit** — each additional home health skilled nursing visit of any duration following the initial visit per calendar day.

A visit begins when the RN or LPN enters the residence to provide a covered service. The visit ends when the RN or LPN leaves the residence at the conclusion of the covered service.

A visit made by a skilled nurse solely to train other home health providers is not a covered service. The home health agency is responsible for ensuring that its providers are properly trained to perform any service it furnishes. The cost of a skilled nurse's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

Topic #2148

Intake Evaluations

Federal regulations require home health agencies to have written policies concerning the acceptance of members by the agency. When personnel of the agency make an intake evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not reimbursable separately as a skilled nursing visit since, at this point, the member has not been accepted for care.

If, however, during the course of this intake evaluation visit, the member is determined suitable for home health care by the agency and is also provided the first skilled nursing service as ordered by the POC (plan of care), the visit would become the first reimbursable home health skilled nursing visit.

Topic #2143

Member Enrollment for Services

According to Wis. Admin. Code § DHS 107.11(2), a member is eligible for home health skilled nursing services if they:

- Require less than eight hours of direct, skilled nursing services in a 24-hour period according to the POC (plan of care).
- Do not reside in a hospital or nursing facility.
- Require a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence.

Topic #2147

Nasopharyngeal and Tracheostomy Suctioning

Nasopharyngeal and tracheostomy suctioning are skilled nursing services and are covered as skilled nursing services if they are required to treat the member's medical condition.

Topic #2146

Ostomy Care

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching of ostomy care is reimbursable during the time that a skilled assessment or another covered skilled nursing care is required.

Topic #2144

Qualifying Hours of Care

A maximum of 30 calendar days of skilled nursing care may continue to be reimbursed as home health services, beginning on the day eight hours or more of skilled nursing services became necessary. To continue medically necessary services after 30 days, PA (prior authorization) for PDN (private duty nursing) is required under Wis. Admin. Code § DHS 107.12(2).

To determine if a member receives less than eight hours of direct skilled nursing services, add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends. If this adds up to **less** than eight hours, the member may enroll for home health skilled nursing services.

If the member requires eight or **more** hours of direct skilled nursing services in a 24-hour period, they may enroll for PDN services. A member cannot be enrolled for both home health skilled nursing services and PDN services.

Topic #2142

Reimbursable Assessments

Assessment of a member's condition is always a part of required nursing supervision. However, the assessment of the member's condition may be reimbursable as a skilled nursing service when:

- The member's medical condition requires a nurse to identify and evaluate the need for possible modification of treatment. This may include when the following indications are present and documented:
  - Abnormal or fluctuating vital signs
  - Weight changes
  - Edema
  - Symptoms of drug toxicity
  - Abnormal or fluctuating lab values
  - Respiratory changes on auscultation

  A one-time visit by an RN (registered nurse) may be medically necessary to assess and evaluate the medical condition of the member in response to a home health aide, PCW (personal care worker), the member or the member's family, or another person expressing concern that the member's medical condition may have changed. This assessment visit may be covered whether or not the visit results in intervention or a change in the POC (plan of care). Providers may request an amendment to a PA (prior authorization) to cover this visit.

  The member's medical condition requires a nurse to initiate additional medical procedures until the member's treatment regimen stabilizes but is not part of an established pattern of care.

A member often requires a skilled nursing assessment during the first 30 days following hospital discharge or until the member's medical condition and treatment regimen stabilizes.

- There is a likelihood of complications or an acute episode requiring a nurse to identify and evaluate the member's need for possible modification of treatment or initiation of additional medical procedures until the member's treatment regimen is essentially stabilized.

  When a member is admitted to home health care for assessment because there is reasonable potential of a complication or further acute episode, the skilled assessment services are covered only for as long as there remains a reasonable potential for such a complication or acute episode. Medical record documentation must support the likelihood of a future complication or acute episode.

Examples of Reimbursable Assessments

The following are examples of reimbursable assessments:

- A member with arteriosclerotic heart disease with unstable congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation or adverse affects from prescribed medication. Skilled assessment is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the member's treatment regimen is essentially stabilized.
- A member has undergone peripheral vascular disease treatment, including a bypass. The incision area is showing signs of potential infection, and the member has an elevated temperature. Skilled assessment of the perfusion of the legs and the integrity of the incision site is necessary until the signs of potential infection have abated.

Topic #2141

Reimbursable Ongoing Assessment Visits

When an assessment visit does not meet the guidelines for medical necessity, it may be reimbursed as an ongoing assessment (Title 19 re-evaluation) visit if all of the following criteria are met:

- The member's medical condition is stable. (A medical condition is considered stable when the member's physical condition is non-acute and without substantial variability at the current time.)
- The member has not received a covered skilled nursing service (including medication management), covered personal care service, or covered home visit by a physician within the past 62 days.
- A skilled assessment is required to re-evaluate the continuing appropriateness of the POC (plan of care).

In accordance with federal Medicaid regulations, the visit must be ordered by a physician in order to be covered. In the ongoing assessment visit, the RN (registered nurse) is required to do the following:

- Assess the member's current medical condition (including systems assessment, environmental assessment, psychosocial assessment, and functional assessment)
- Evaluate the member's progress or lack of progress towards meeting established goals
- Modify the POC as needed

The ongoing assessment visit is to be used to assess the member who is only receiving home health aide services or home health aide and home health therapy services. Persons receiving covered skilled nursing visits must be assessed during those covered visits. Skilled nursing services include the following:

- PDN (private duty nursing) provided by an RN or LPN (licensed practical nurse)
- PDN for ventilator-dependent members provided by an RN or LPN

- Initial or subsequent home health nursing visits
- Personal care supervisory visits

Wisconsin Medicaid may reimburse for ongoing skilled nursing assessments and visits provided once every 55 calendar days.

PA (prior authorization) is not required for an ongoing assessment visit. Providers are required to submit claims using the ongoing assessment visit procedure code.

Examples of Non-Reimbursable Ongoing Assessments

The following are examples of non-reimbursable ongoing assessments:

- A physician orders one skilled nursing visit every two weeks and three PCW (personal care worker) visits each week for bathing and washing hair for a member whose recovery from a cerebral vascular accident has caused a residual weakness on the left side. The member's condition is stable and the member has reached the maximum functional independence. There are currently no underlying conditions that would necessitate a skilled assessment, therefore, an ongoing assessment visit would not be covered in this situation because a personal care visit is more appropriate.
- A visit that is made specifically for filling out paperwork, such as an OASIS (Outcome and Assessment Information Set), is not covered.

Topic #2140

Reimbursable Teaching and Training Activities

Teaching and training activities that require skilled nursing personnel to teach a member, the member's family, or unpaid caregivers how to manage the treatment regimen would constitute skilled nursing services only when provided to a member in conjunction with other reimbursable skilled nursing services.

When it becomes apparent after a reasonable period of time that the member, family, or caregiver is unwilling or unable to learn or be trained, further teaching and training ceases to be reasonable and medically necessary. The reason that the member, family, or caregiver is unwilling or unable to be trained should be documented in the medical record.

Examples of Reimbursable Teaching and Training Activities

The following are examples of reimbursable teaching and training activities:

- A provider acting within the scope of their practice has ordered skilled nursing services for a man who was hospitalized for a broken hip and has now been discharged to home. While hospitalized, the member was newly diagnosed with diabetes. Skilled nursing care is ordered to closely monitor blood glucose levels until the levels stabilize and to assess understanding of and compliance with a diabetic diet. In this case, teaching of self-injection and management of insulin, signs and symptoms of insulin shock, and actions to take in emergencies is reasonable and necessary to the treatment of the medical condition, since the member is receiving skilled care and cannot reasonably be expected to go to his physician for the instruction.
- A member with arteriosclerotic heart disease and congestive heart failure requires close observation by a nurse for signs of decompensation or adverse affects resulting from newly prescribed medication. When visiting the member to assess his or her medical condition, teaching about the medication regimen is appropriate. (Under Wisconsin pharmacy law and Wisconsin Medicaid regulations, pharmacists are required to instruct the person picking up a prescription about the medication, including instructions for administration and signs of adverse reactions. In most cases, the person obtaining the prescription may also obtain this information over the telephone.)

Topic #2139

Reimbursable Venipunctures

Venipuncture is a skilled nursing service when the collection of the specimen is necessary to the diagnosis and treatment of the member's medical condition and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment. The frequency of visits for venipuncture must be reasonable within accepted standards of medical practice for treatment of the medical condition. Venipuncture is reasonable and necessary when the following occurs:

- The treatment is recognized as being reasonable and medically necessary to the treatment of the medical condition. The physician order for the venipuncture should clarify the need for the test when it is not diagnosis/illness specific.
- The frequency of the testing is consistent with accepted standards of medical practice for continued monitoring and assessment of a diagnosis, medical problem, or treatment regimen. Even when the laboratory results are consistently stable, periodic venipunctures may be reasonable and necessary because of the nature of the treatment.

Reimbursable Venipuncture for Prothrombin

Venipuncture may be reimbursable when the following is true:

- Documentation shows that the dosage is being adjusted and ongoing monitoring is ordered by the physician.
- The results are stable within non-therapeutic ranges. There must be documentation of other factors that would indicate why continued monitoring is reasonable and medically necessary.
- The results are stable within the therapeutic ranges. Monthly monitoring may be reasonable and necessary.

Examples of Reasonable and Necessary Venipunctures

The following are examples of reasonable and necessary venipuctures:

- Many medications may cause side effects, such as leukopenia and agranulocytosis, and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every three months) when the results are stable and the member is asymptomatic.
- In monitoring phenytoin (for example, Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight. It is therefore appropriate to monitor the level on a routine basis (every three months) when the results are stable and the member is asymptomatic.
- A member with coronary artery disease was hospitalized with atrial fibrillation and was subsequently discharged to the home health agency with orders for anticoagulation therapy. Monthly venipunctures as indicated are necessary to report prothrombin (protime) levels to the physician.

Topic #2138

Supervision

In accordance with licensure requirements and as stated in Wis. Admin. Code ch. N 6, LPNs (licensed practical nurses) are required to be supervised by an RN (registered nurse) or a physician.

Ongoing supervision of a home health aide, LPN, or PCW (personal care worker) must be provided in accordance with Wis. Admin. Code § DHS 105.16(2)(b).

Supervisory visits must include:

- A review and evaluation of the member's medical condition and medical needs according to the written POC (plan of care) during the period in which agency care is being provided

- An evaluation of the appropriateness of the relationship between the direct care giver and the member
- An assessment of the extent to which the member's goals are being met
- A determination of whether or not the current level of home health services provided to the member continues to be appropriate to treat the member's medical condition
- A determination of whether or not the services are medically necessary
- A discussion and review with the member about the services received by the member

After each supervisory visit, the RN must discuss the results of the supervisory visits with the home health aide, LPN, or PCW. The results of each supervisory visit must be documented in the member's medical record.

Separate reimbursement for supervisory visits is limited to PCW supervisory visits. Specific information on the supervision of PCWs is available in the Personal Care area of the Online Handbook.

Topic #2137

Tube Insertions and Feedings

Nasogastric, gastrostomy, and jejunostomy tube feeding are covered services. Replacement, stabilization, and suctioning of the tubes are also covered skilled nursing services.

If the feeding of a member via gastrostomy or jejunostomy tube is delegated to an LPN (licensed practical nurse), home health aide, or PCW (personal care worker), medical record documentation must support that the caregiver has been instructed in all aspects of tube feeding. This delegation may occur only when deemed appropriate by the supervising RN (registered nurse) after assessment of the member's medical condition.

Topic #2136

Wound Care

Wound care relates to the direct, hands-on skilled nursing care provided to members with wounds, including any necessary dressing changes on those wounds.

Wound care, including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, and tube sites, is a skilled nursing service when the skills of a licensed nurse are needed to safely and effectively care for the wound. For skilled nursing care to be reasonable and necessary to treat a wound, the grade, size, depth, nature of drainage (color, odor, consistency, and quantity), condition, and appearance of the surrounding skin of the wound must be documented in the POC (plan of care). This allows an assessment of the need for skilled nursing to be made.

The POC must contain the specific instructions for the wound treatment. Where the prescribing provider has ordered appropriate active treatment (for example, sterile or complex dressings, administration of prescription medications) of wounds with the following characteristics, the skills of a licensed nurse may be reasonable and necessary:

- Open wounds that are draining purulent exudate or that have a foul odor present and/or for which the member is receiving antibiotic therapy
- Wounds with a drain or T-tube that require interval position changes
- Wounds that require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze
- Recently debrided ulcers
- Pressure sores (decubitus ulcers) that present the following characteristics:
    - Partial tissue loss with signs of infection, such as foul odor or purulent drainage
    - Full thickness tissue loss that involves exposure of fat or invasion of other tissue, such as muscle or bone

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed
- Open wounds or widespread skin complications following radiation therapy or that result from immune deficiencies or vascular insufficiencies
- Post-operative wounds where there are complications, such as infection or allergic reaction, or there is an underlying disease that has a reasonable potential to adversely affect healing (for example, diabetes)
- Third degree burns and second degree burns, where the size of the burn or presence of complications causes skilled nursing care to be needed
- Other open or complex wounds that require treatment that can be safely and effectively provided only by a licensed nurse

For skilled nursing services to continue, there must be ongoing medical record documentation of the grade, size, depth, nature of drainage, and condition of the wound and appearance of surrounding skin.

Skilled nursing care is ordinarily not required for wounds or ulcers that show redness, edema and induration, at times with epidermal blistering or desquamation. Wounds that only require an antibacterial ointment, nonsterile covering, occlusive covering, opsite or duoderm, and wounds with minimal serous or serosanguinous drainage also do not require skilled nursing care.

However, while the initial care for a wound might not require the services of a skilled nurse, the wound may still require skilled monitoring and assessment for signs and symptoms of infection or complication.

Home Health Skilled Nursing Visits for Medication Management and Administration

Topic #2106

Available Alternatives to Medication Management Visits

Several alternatives are available to assist in meeting members' medication needs and should be considered when determining the medical necessity and frequency of medication management visits.

A variety of dispensing devices, adaptive aids, and delivery systems are available to assist a member in dispensing his or her own medication. Examples of these include:

- Insulin pens
- Medication dispensers
- Medication organizers
- Alarms

Providers should contact the member's prescribing provider to determine if prescribing one of these products would be appropriate for the member.

Insulin Pens

For each fill, Wisconsin Medicaid covers up to a three-month supply of prefilled insulin pens and cartridges through the pharmacy benefit. A pharmacy can submit claims to ForwardHealth for prescriptions for insulin products and supplies.

Combining Services

In consultation with the member's prescribing provider, home health agencies should determine the best combination of medication management visits and use of alternative dispensing devices, adaptive aids, and delivery systems appropriate to the member's condition.

Topic #2105

Community Vaccination Clinics

Home health agencies may submit claims to ForwardHealth for medically necessary influenza and pneumococcal vaccinations provided at community vaccination clinics. There must be established written protocol, policy, and guidelines that are approved by the agency's medical director.

Providers are required to submit a separate UB-04 claim form using the appropriate procedure code for each member receiving these vaccines. ForwardHealth does not accept rosters of members who received vaccines.

Topic #2104

Eye Drops and Topical Ointments

The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eye drops or ointments is necessary for the treatment of an illness or injury and the member cannot self-administer them, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. However, administration can be provided during a covered skilled nursing visit for observation and assessment of the member's condition.

Topic #2103

Home Vaccination

Home health agencies may administer the influenza and pneumococcal vaccines to members who they are currently serving when there is a physician order for the vaccination.

A nurse is required to administer the vaccine during an already scheduled home health skilled nursing visit. Wisconsin Medicaid does not reimburse for a home health skilled nursing visit if administration of the vaccination is the only purpose for the visit.

Providers should submit claims for influenza and pneumococcal vaccinations using the UB-04 claim form. When billing for a vaccine, providers should list both the procedure code appropriate for the type of home health skilled nursing visit (initial or subsequent) and the procedure code for the type of vaccine administered.

Coverage for Influenza Services

The following ForwardHealth programs cover medically necessary influenza services (both 2009 H1N1 and seasonal influenza):

- BadgerCare Plus
- Express Enrollment for Children
- Express Enrollment for Pregnant Women
- Medicaid

Topic #2102

Intravenous, Intramuscular, or Subcutaneous Injections and Infusions or Intravenous Feedings

Intravenous, intramuscular, or subcutaneous injections and infusions or intravenous feedings require the skills of a nurse to be performed safely and effectively. The medication being administered must be accepted as safe and effective treatment of the member's medical condition, and there must be a medical reason that the medication cannot be taken orally. With the exception of intravenous medications and infusions, these tasks are reimbursable only as medication management visits.

The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances that justify the need for additional injections.

Insulin Injections

Insulin injections by a nurse are not usually considered skilled nursing services. Insulin is customarily self-injected by members or injected by their families, although assistive devices may sometimes be required. However, the injections would be considered a reasonable and necessary skilled nursing service when a member cannot reasonably obtain services outside the residence, is either physically or mentally unable to self-inject insulin (even with the aid of assistive devices), and there is no other person who is able

and willing to inject the member. These services are not covered when a member is eligible for insulin injections and other home health services through Medicare or another insurance provider.

Vitamin B-12 Injections

Vitamin B-12 injections are considered specific therapy only for the following conditions:

- Alcohol neuropathies
- Anastomosis or partial resection of small intestines
- Anemia, fish tapeworm
- Anemia, macrocytic
- Anemia, megaloblastic
- Anemia, pernicious
- Anemia, post-bowel resection
- Anemia, post-gastrectomy syndrome
- Blind loop syndrome
- Cancer of stomach, liver, intestines, and colon
- Crohn's disease
- Posterolateral sclerosis
- Sprue or other malabsorption states
- Strictures of small intestine

Tuberculosis Skin Test

Tuberculosis skin tests and the reading of those tests are covered only when they are part of an already scheduled, covered skilled nursing visit, and there is a physician's order for the service. Wisconsin Medicaid does not reimburse for skilled nursing visits when the administration of a tuberculosis skin test is the only purpose for the visit.

Topic #2101

Medication Management Coverage Guidelines

Medication management visits must adhere to the following guidelines:

- **All nursing services must be consolidated into one visit whenever possible.** A medication management visit **may** be billable on the same DOS (date of service) as a home health skilled nursing visit or personal care supervisory visit when more than one visit is **medically necessary.**
- An ongoing assessment visit is not covered if the member has received a medication management visit within the past 62 days.
- The 30-visit home health PA (prior authorization) threshold includes medication management visits.
- If a member is unable to fill their own insulin syringes by the many methods available, prefilled insulin pens are not an appropriate alternative, and a pharmacy is unavailable to fill syringes, medication management visits to fill syringes may be authorized.
- Medication set up may be medically necessary to ensure the medication program is followed correctly, especially when a member is taking multiple prescriptions at various times during the day. It may also be necessary to allow safe delegation of administration to an unlicensed caregiver.
    - Alternatives to setting up medications, such as picture charts, color coding, and alarm caps, should be considered.
    - Medication set up is normally done on a biweekly basis. Requests for a more frequent set up schedule must be documented as medically necessary and will be determined on a case-by-case basis.
    - Any additional visit to set up missing medications is not covered because Wisconsin Medicaid only reimburses for a completed service, not a partial service. For example, if a medication was not reordered appropriately to completely

fill out a member's two-week planner, an additional visit to finish filling out the planner would not be covered.

- In some cases, a mix of home health skilled nursing visits and medication management visits is appropriate. To determine if a visit is for the purpose of medication management or home health skilled nursing, the provider should ask "If no medication management services were needed, would the visit otherwise qualify as a covered home health skilled nursing visit?"
- Medication management visits may be medically necessary and appropriate on a PRN (pro re nata), or "as needed," basis. Such PRN visits may be included in PA requests that include documentation that the request is reasonable.

Topic #2100

Medication Management Covered Services

A medication management visit may include the following services:

- Administering medication, other than intravenous, requiring the skills of a nurse when administration cannot be delegated safely to a home health aide or PCW (personal care worker).
  - Intravenous fluid or medication administration may be billed as a home health skilled nursing visit.
  - Intramuscular and subcutaneous injections are considered medication management visits. This includes sliding scale insulin injections.
- Prefilling syringes for self-injection when the member is not capable and a pharmacy is not available.
- Setting up medication for self-administration, administration, or assistance with administration by an unlicensed caregiver when the member is not capable and a pharmacy is not available. Medication set up includes changing medications, programming an electronic medication dispenser, and instructing the member about the medication program and use of the dispenser.
- Providing other services directly related to a medication program, such as teaching related to a member medication regimen, determined on a case-by-case basis.

Topic #2099

Medication Management Overview

A medication management visit is a medically necessary visit in which a nurse provides medication management when the member is physically or cognitively unable to follow a medication program without assistance, and no other willing and able caregiver is available.

Only a nurse may provide medication management services for the member. The following tasks may be delegated by an RN (registered nurse) to either a home health aide or PCW (personal care worker):

- Assistance with medication administration
- Medication administration other than by intramuscular or subcutaneous injection, nasogastric, or intravenous administration

Providers cannot submit claims using procedure code T1502 (Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit) for medication assistance or administration provided by a home health aide or PCW.

If skilled nursing services are provided in conjunction with medication management services, the visit is considered a home health skilled nursing visit.

Topic #2098

Oral Medications

The administration of oral medications to a member is not a reasonable or medically necessary skilled nursing service except when the complexity of the member's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

Topic #2097

Psychiatric Medication Management Visits

Medication management services for members with mental illness are generally provided under other BadgerCare Plus or Medicaid benefits.

Medication management services are provided as part of CSP (community support program) services; therefore, they are not covered home health services for members receiving covered CSP services as stated in Wis. Admin. Code § DHS 107.11(5)(h). Refer to the CSP service area for further information. Medication management services are also not covered home health services when these services are provided under outpatient psychotherapy and day treatment services, according to Wis. Admin. Code § DHS 107.11(5)(h).

PA (prior authorization) requests must document information on a member's enrollment status in a CSP, day treatment, or other mental health service that can provide medication management services to the member.

All home health skilled nursing criteria apply when medication management services for mental health members are provided under home health services. This includes the following:

- The services are medically necessary, and the member requires a considerable and taxing effort to leave the residence or cannot reasonably obtain these services outside the residence.
- The medication management service must meet the criteria of the home health benefit.

If providers are not certain what resources are available for a particular mental health member, contact the member's county community services board per Wis. Stat. § 51.42. This agency, as specified under Wis. Stat. ch. 51, is responsible for providing or arranging services for its citizens with mental health needs. Contact the member's income maintenance or tribal agency for the agency's contact information.

Home Health Therapy Services

Topic #2135

Cotreatment

Cotreatment (interdisciplinary treatment) is simultaneous treatment by two providers of different therapy disciplines during the same time period. If a member requires multiple therapies, and each therapy has a unique approach to the member's treatment, the therapies should be separately and independently provided to give the member the maximum benefit and opportunity for rehabilitation. Providers are also required to meet PA requirements for cotreatment.

Topic #2134

Definition

As stated in Wis. Admin. Code § DHS 107.11(2), the following types of medically necessary skilled therapy services provided by a home health agency are covered:

- PT (physical therapy)
- OT (occupational therapy)
- SLP (speech and language pathology)

Topic #2133

Examples

The following are examples of reimbursable home health therapy visits:

- A member with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of their condition that has left them wheelchair bound and, for the first time, without any expectation of achieving ambulation again. The physician has ordered OT (occupational therapy) to select the proper wheelchair for their long-term use, to teach the member and their family safe use of the wheelchair and safe transfer techniques in their home. OT would be reasonable and necessary to evaluate the member's overall needs, to make the selection of the proper wheelchair, and to teach the member and/or family safe use of the wheelchair, proper transfer techniques, and other self-care activities.
- A physician prescribes PT (physical therapy) treatments three times a week for 45 days for a member who has been discharged from the hospital following a recent hip fracture. The member was discharged using a walker for seven days from the start of home care. The POC (plan of care) shows that the member was discharged from the hospital with restricted mobility in ambulation, transfers, and climbing of stairs. The member has an unsafe gait that indicates a need for gait training, and the member had not been instructed in stair climbing and a home exercise program. The goal of the PT will be to increase strength and range of motion, to progress from walker to cane with safe gait, and to address stair climbing. The services are reasonable and necessary for the treatment of the member's medical condition.

Topic #2132

Home Health Therapy Visits

A home heath therapy visit is a visit of any duration by a physical therapist, occupational therapist, or speech-language pathologist for a period of therapy service. Only one PT (physical therapy) visit, OT (occupational therapy) visit, and SLP (speech-language pathology) visit, per member, per day, is reimbursable by Wisconsin Medicaid.

A visit begins when the therapy provider enters the residence to provide a covered service. The visit ends when the therapy provider leaves the residence.

A visit made by a therapy provider solely to train other home health providers is not a covered service. The home health agency is responsible for ensuring that its providers are properly trained to perform any service it furnishes. The cost of a skilled therapy provider's visit for the purpose of training home health agency providers is an administrative cost to the home health agency.

Topic #2131

Medically Necessary Skilled Therapy Services

Services that may only be performed safely and effectively by a skilled physical therapist, occupational therapist, or speech-language pathologist are considered skilled therapy services. Wisconsin Medicaid will cover only skilled therapy services that are medically necessary. The skilled therapy services must be consistent with the nature and severity of the member's medical condition and functional status. The amount, frequency, and duration of the services must also be medically necessary and must not duplicate other services being provided.

The skilled therapy services must be provided with the expectation of **one** of the following outcomes, based on the physician's assessment of the member's rehabilitation potential:

- The condition of the member is expected to improve materially in a reasonable and generally predictable period of time.
- The services are necessary to the establishment of a safe and effective maintenance program.

Also, the member must show the following:

- Motivation, interest, or desire to participate in home health therapy. The frequency and amount of home health therapy should depend on the member's demonstrated response to current therapy and/or estimated response to proposed therapy.
- Progress toward meeting or maintaining established measurable goals or show carryover (follow-through of activities or skills learned) within six months of treatment at home.

The skilled therapy services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the member's condition.

Services of skilled therapy providers that are for the purpose of teaching the member or the member's family or caregivers necessary techniques, exercises, or precautions are covered to the extent that they are reasonable and necessary to treat the medical condition. Direct treatment must be provided during family or caregiver education session(s).

The therapy provider is required to provide a summary of all therapy activities, including goals and outcomes, to the member's physician at least every 62 days, and also upon the completion of therapy services to the member.

Topic #2129

Providers of Services

Home health therapy services are provided by physical therapists, occupational therapists, and speech-language pathologists through home health agencies. The therapy providers may be any of the following:

- Employed by the home health agency
- Employed by an agency under contract with the home health agency
- Independent providers under contract with the home health agency

Therapy providers employed by, or under contract with, home health agencies are required to meet all Medicaid enrollment requirements, but they are not required to be individually enrolled in Wisconsin Medicaid. The home health agency is required to maintain records showing that its individual providers meet Medicaid requirements.

Topic #2128

Supervision of Assistants

A physical therapist, occupational therapist, or speech-language pathologist is required to be physically present at a member's residence to supervise an assistant. The supervising physical therapist, occupational therapist, or speech-language pathologist is required to be of the same therapy discipline as the assistant. The agency may bill for the services of either the physical therapist, occupational therapist, speech-language pathologist, or the assistant during any one visit; the agency may not bill for both professionals at the same time.

Topic #2127

Therapy Evaluation

A therapy evaluation must be completed prior to the development of a therapy POC (plan of care). The evaluation must be reviewed, signed, and dated by the rendering therapy provider, who must be identified as such on the evaluation. The evaluation must include the comprehensive results of formal/informal tests and measurements that provide a baseline for the member's functional limitations from which a POC is established. The evaluation must include written instructions for follow through or carryover by the member and/or caregiver. Follow through or carryover must be realistically achievable by the member and/or caregiver at the place of residence.

Topic #2126

Therapy Plan of Care

A therapy POC (plan of care) must be completed prior to the provision of home health therapy services. The therapy POC must contain specific and measurable goals that are related to an identified deficit and are appropriate to the member's chronological or developmental age, way of life, and home situation. The therapy goals must be medical in nature, rather than educational, social, or vocational.

Noncovered Services

Topic #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. Wis. Admin. Code § DHS 101.03 (103) and Wis. Admin. Code ch. 107 contain more information about noncovered services. In addition, Wis. Admin. Code § DHS 107.03 contains a general list of noncovered services.

Topic #104

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member (or authorized person acting on behalf of the member) for certain noncovered services or activities provided in connection with covered services, including:

- Charges for missed appointments
- Charges for phone calls
- Charges for time involved in completing necessary forms, claims, or reports
- Translation services

Missed Appointments

Federal CMS (Centers for Medicare and Medicaid Services) does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by phone or postcard) before scheduled appointments.
- If a member needs help getting transportation to a medical appointment, encourage the member to call the NEMT (non-emergency medical transportation) manager contracted with Wisconsin DHS (Department of Health Services). Most Medicaid and BadgerCare Plus members can receive NEMT services through the NEMT manager if they have no other way to receive a ride. Refer to the NEMT service area for more information.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation and Interpretive Services

Translation services, which refer to translation of the written word, are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member (or authorized person acting on behalf of the member) for translation services.

Interpretive services, which refer to interpretation of the spoken word or sign language, are a covered service. More information on interpretive services can be found in the Interpretive Services topic.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at 608-266-9372 for information about when translation services are required by federal law. Providers may also write to the following address:

AA/CRC Office
201 E Washington Ave Room B300
PO Box 7850
Madison WI 53707-7850

Private Duty Nursing Services

Topic #2025

Daylight Savings Time

Wisconsin Medicaid reimburses only for the number of hours actually worked. Providers who work when daylight savings time ends are still required to adhere to the limitations on authorized services. Nurses are expected to adjust their schedules in advance to accommodate changes in the clock time.

Providers should adhere to the limits on authorized PDN (private duty nursing services) services.

Topic #2096

Emergency Procedures

As required by Wis. Admin. Code § DHS 105.16(10)(e), all agencies providing PDN (private duty nursing) are required to have the following back-up and emergency procedures in place:

- Have identified another nurse on the case as a backup to provide services to the member in the event the scheduled nurse is temporarily unable to provide services. Providers are required to inform members of the backup nurse's name before the backup nurse provides services.
- Have a written plan for member-specific emergency procedures in the case of a life-threatening situation, fire, or severe weather warnings. Home health agencies are required to give this plan to the member and all caregivers prior to the initiation of these procedures.
- Take appropriate action in the case of any significant accident, injury, or adverse change in the member's condition. Nurses are required to immediately notify the member's physician, guardian (if any), and any other responsible person designated in writing by the member or member's legal representative.

Topic #13958

Managing Authorized Units Within 13-Week Segments

Unused hours authorized for one 13-week segment do not carry over to another 13-week segment. If the member's condition changes and more hours will be needed to provide medically necessary services, the POC (plan of care) needs to be updated and reviewed, signed, and dated by the attending physician. If the change in condition is temporary and PRN (pro re nata) hours are needed, then the physician orders must specify the dates when additional medically necessary services are to begin and end. To obtain PA (prior authorization) for medically necessary PRN hours, the PAL (prior authorization liaison) is required to submit an amendment request. Pro re nata hours will not be authorized for any 13-week segment that is authorized for flexible use of hours.

Topic #2092

Member Eligibility for Services

According to Wis. Admin. Code § DHS 107.12(1)(a), a member is eligible for PDN (private duty nursing) services if they:

- Require a total of eight or more hours of direct skilled nursing services in a 24-hour period according to the POC (plan of care).
- Do not reside in a hospital or nursing facility.
- Have a written POC specifying the medical necessity for PDN services.

Ventilator-Dependent Members

In accordance with Wis. Admin. Code § DHS 107.113(1), a ventilator-dependent member is eligible for respiratory care when they meet all of the criteria for PDN services and meet the following requirements:

- Are medically dependent on a ventilator for life support at least six hours per day. In addition, the member is required to meet one of the following two conditions:
  - Has been hospitalized for at least 30 consecutive days for their respiratory condition. The 30 consecutive days may occur in more than one hospital or nursing facility.
  - If they have been hospitalized for less than 30 days, their enrollment for services will be determined by the DMS (Division of Medicaid Services) Chief Medical Officer on a case-by-case basis. The Chief Medical Officer's determination may include discussions with the member's pulmonologist and/or primary care physician to evaluate the member's diagnosis, prognosis, history of hospitalizations for the respiratory condition, and weaning attempts, when appropriate.
- Has adequate social support to be treated at home and desires to be treated at home.
- May have ventilator care safely provided at home.

Topic #2091

Member Medical Record

Home health agencies are required to maintain a medical record for each member receiving PDN (private duty nursing) services as stated in Wis. Admin. Code § DHS 105.16(10)(d). The record must document the nature and scope of all services provided and be systematically organized and readily accessible to ForwardHealth. The medical record must include all of the following:

- Member identification information.
- The member's condition, problems, progress, and all services rendered.
- Appropriate hospital information supplied by the hospital, including discharge information, diagnosis, current patient status, and post-discharge POC (plan of care).
- An admission evaluation and assessment of the member.
- All medical orders, including the current physician written POC and all interim physician's orders. The Plan of Care chapter contains further information about a physician's verbal orders.
- A consolidated list of medications, including start and stop dates, dosage, route of administration, and frequency. This list must be reviewed and updated for each nursing visit, if necessary.
- Progress notes posted as frequently as necessary to clearly and accurately document the member's status and services provided. A "progress note" is a written notation, timed, dated, and signed by a member of the health team providing covered services, that summarizes facts about the care furnished and the member's response during a given period of time.
- Clinical notes written, timed, signed, and dated the day service is provided and incorporated into the medical record within seven days. A copy of these notes should be maintained in the record in the member's home. These notes are a notation of contact with a member that document the PDN services provided and should do the following:
  - Describe the member's medical status, including signs and symptoms.
  - List the time and date of the contact, a description of treatment and drugs administered, and the member's reaction.
  - Describe any changes in the member's physical or emotional condition and any nursing intervention.

    Nurses are encouraged to write clinical notes as services are provided and complete them by the end of each shift. These notes should be utilized by nurses performing services during subsequent shifts in order to maintain continuity of care.

- Written summaries of the member's care provided by the nurse to the physician at least every 62 days.

The following information must be included in the documentation concurrent to the notation of service in both progress notes and clinical notes:

- The date and time of service.
- The signature and title of the rendering provider.

All physician-ordered treatments and interventions included in the POC must be documented in the member's medical record.

For ventilator-dependent members, the ventilator settings, parameters, and the ventilator checks must also be documented in the member's medical record at least for each nurses' shift.

The results of each supervisory visit must be documented in the member's medical record.

Topic #4897

Members with Changing Nursing Needs

During a member's course of treatment, the number of hours of nursing services they require may change. As a result, the member may transition from home health services to PDN (private duty nursing) services or the member may no longer require PDN services. When a change in the level of service occurs, ForwardHealth requires notification to end the PA (prior authorization). If the member's needs change from PDN to home health services, the home health provider is required to submit a new PA request to Wisconsin Medicaid.

Members Changing to Private Duty Nursing

If the condition of a member receiving home health skilled nursing services changes to the point that eight or more hours of direct, skilled nursing care are required in a calendar day, the member is no longer eligible for home health skilled nursing services. For reimbursement of covered PDN services, ForwardHealth must authorize PDN services for the member.

Topic #2095

Place of Service

As stated in Wis. Admin. Code § DHS 107.12(1)(a), members who are authorized to receive PDN (private duty nursing) services in the home may make use of approved hours of service outside the home setting during those hours when a member's normal life activities take them outside the home setting.

Topic #2094

Providers of Services

Only RNs (registered nurses) and LPNs (licensed practical nurses) can provide PDN (private duty nursing). The following PDN services can only be performed by an RN:

- The initial evaluation visit.
- Initiating the physician's POC (plan of care) and any necessary revisions.

- Providing those services that require the care of an RN as defined in Wis. Admin Code ch. N 6.
- Initiating appropriate preventive and rehabilitative procedures.
- Regularly evaluating the member's needs.
- Acting as the PDN PAL (prior authorization liaison).

Nursing services not requiring an RN may be provided by an LPN under the supervision of an RN. An LPN's duties include the following:

- Performing nursing acts delegated by an RN under Wis. Admin. Code § N 6.03.
- Assisting the member in learning appropriate self-care techniques.
- Meeting the nursing needs of the member according to the written POC. All nursing acts performed must be within the professional scope of practice for the LPN.

In accordance with Wis. Admin. Code § DHS 105.16(10)(a)3, both RNs and LPNs are required to do the following:

- Arrange for or provide health care counseling within the scope of nursing practice to the member and the member's family in meeting the needs related to the member's condition.
- Provide coordination of care for the member, including ensuring that provision is made for all required hours of care for the member.
- Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience.
- Within 24 hours of providing service, prepare written clinical notes that document the care provided and incorporate them into the member's medical record within seven days.
- Promptly inform the physician and other personnel participating in the member's care of changes in the member's condition and needs.

Ventilator-Dependent Members

Only RNs and LPNs may provide PDN services to ventilator-dependent members. The provider is required to document that the appropriate home health agency staff are qualified to perform all of the following services:

- *Tracheostomy care*. Stoma care, suctioning, humidification, changing a tracheostomy tube, and emergency procedures for tracheostomy care.
- *Oxygen therapy*. Operation of oxygen systems and auxiliary oxygen devices, and written documentation of the member's oxygen needs.
- *Operation and interpretation of monitoring devices*. Types of cardio-respiratory monitoring, pulse oximetry, and capnography.
- *Operation of ventilators*. Positive pressure or negative pressure ventilation.
- *Other respiratory therapies*. Continuous positive airway pressure, chest physiotherapy, respiratory assessment, and operation of aerosol and humidity devices.
- *Pulmonary rehabilitation*. Maintenance and restoration of the member's physical functioning, modification of the member's immediate living environment, assessment of the member's activities of daily living.

Topic #2093

Qualifying Hours of Care

To determine if a member receives eight or more hours of direct skilled nursing services, add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends. If the total time required daily for these cares is equivalent to eight or more hours, the member is eligible for PDN (private duty nursing). The POC (plan of care) is required to include the actual amount of time to be spent on medically necessary direct cares that require the skills of a licensed nurse.

For this purpose, ForwardHealth-covered skilled nursing services may include, but are not limited to, the following:

- Injections
- Intravenous feedings
- Gastrostomy feedings (include the time needed to begin, disconnect, and flush — not the entire time the feeding is dispensing)
- Nasopharyngeal and tracheostomy suctioning
- Insertion and sterile irrigation of catheters
- Application of dressings involving prescription medications and aseptic techniques
- Treatment of extensive decubitus ulcers or other widespread skin disorders

Reasonable time for record keeping, travel, staff training, supervision, and case management are allowable costs that have been included in the rates established for PDN hours. Therefore, the time spent on these activities is not separately reimbursable.

If the member requires fewer than eight hours of direct skilled nursing services in a 24-hour period, they may be eligible for home health skilled nursing services. A member cannot be concurrently enrolled for both PDN and intermittent part-time skilled visits provided by nurses.

Topic #2090

Reimbursement Requirements

Wisconsin Medicaid reimburses PDN (private duty nursing) services as part of the PDN benefit if the services:

- Meet the criteria to be classified as PDN services.
- Are prior authorized.
- Are prescribed by a physician in accordance with Wis. Stat § 49.46(2).
- Are provided to members enrolled under Wis. Stat § 49.47(6)(a).
- Are implemented according to Wis. Admin. Code ch. DHS 107.
- Are provided in accordance with the member's POC (plan of care). Services provided to the member that are not on the POC are not covered services.

Topic #8598

Work Hour Limitations

The nurse providing PDN (private duty nursing) or PDN-Vent (private duty nursing to members depending on a ventilator) may not provide nursing service in excess of 12 hours in a calendar day and 60 hours in a calendar week to all members and other patients under the nurse's care, as stated in Wis. Admin. Code §§ DHS 107.113(5)(d), and 107.12(4)(f) and (g).

The nurse is also required to take at least eight continuous and uninterrupted hours off duty in any 24-hour period during which they perform PDN or PDN-Vent services that are reimbursed by Wisconsin Medicaid, as stated in Wis. Admin. Code §§ DHS 107.12(4)(g) and 107.113(5)(g).

PDN or PDN-Vent services provided in excess of the calendar day and calendar week limits are not covered. Services provided when the nurse does not meet the off-duty requirements are also considered noncovered services.

Definitions for a Calendar Day and a Calendar Week

The following definitions are applicable to PDN and PDN-Vent:

- A calendar day is a span of 24 hours beginning at midnight and ending at midnight (for example, midnight on June 1 to midnight on June 2). A calendar day should not be confused with a 24-hour period.
- A 24-hour period consists of 24 consecutive hours. A 24-hour period can begin at any time during the day and may include hours from two different calendar days (for example, 9 a.m. on June 1 to 9 a.m. on June 2)
- A calendar week begins with Sunday, ends with Saturday, and consists of seven consecutive calendar days.

Exceptions to these rules may exist in extremely rare circumstances. Requests for exceptions should be made in writing to:

ForwardHealth Home Care Analyst
Division of Medicaid Services
201 E Washington Ave Rm B300
Madison WI 53703

Electronic Visit Verification

4

Archive Date:08/03/2026

Electronic Visit Verification:Claims

Topic #21737

Billing for Time Worked

For ease of use, DHS (the Wisconsin Department of Health Services) allows workers to check in to a visit using an EVV (electronic visit verification) system when they arrive and check out just prior to leaving. During the time of the visit, however, the worker may take a break or may perform services outside the scope of the personal care or home health services being billed, which are noncovered. The provider must only bill for the time spent providing covered personal care or home health services.

For example, if a worker checked in at 9 a.m. and checked out at 1 p.m., but during that time took a half-hour lunch break, the units/minutes billed must only include the time spent directly providing services.

Note: Providers may require workers to check out of their EVV system during the time they are not providing an EVV service.

Topic #22858

Claim Edits

When DHS (the Wisconsin Department of Health Services) receives a claim or encounter detail that requires use of an EVV (electronic visit verification) system, the DHS system will confirm that EVV data exists for the claim and will validate that data for each applicable detail on the claim. To avoid delays in claim adjudication, providers should confirm that all applicable EVV visits for claims are in a verified status prior to submitting a claim.

There are two system edits that look for corresponding data:

1. The first EVV claim edit compares:
    - Billing provider
    - Member Medicaid ID
    - Detail procedure code
    - DOS (date of services)
2. The second EVV claim edit compares the units of time billed to the units of time captured by EVV.

If there is no EVV data corresponding to the criteria required in the first edit, the claim detail will suspend and the claim will recycle through the system for up to two days.

If a detail passes the first EVV system edit, it will continue on to the second EVV system edit where the units of time billed are compared to the units of time captured in EVV. The EVV units should be equal to or greater than the units billed to pass this second edit.

Topic #23139

Medicare Crossover Claims

DHS (the Wisconsin Department of Health Services) does not require use of an EVV (electronic visit verification) system for Medicare crossover claims. However, providers may choose to require workers to capture EVV information for all HHCS (home health care services) services that would normally require EVV. Capturing EVV information for all required services builds

consistent practice and ensures EVV information is captured for all visits that require it.

Topic #23140

Outpatient Services

Outpatient services, distinct from home health care services, do not require use of an EVV (electronic visit verification) system. Claim types are one distinction DHS (the Wisconsin Department of Health Services) uses to distinguish outpatient services from home health care services. Outpatient services are billed on professional claims while home health care services are billed on institutional claims. Home health care providers using institutional claims are required to collect EVV information for all HHCS (home health care services) service codes. Providers who are allowed to bill for HHCS (home health care services) codes on a professional claim are not required to collect EVV information.

Topic #21718

Overnight Visits

When a single visit covers more than one DOS (date of service) (for example, a visit starting Monday at 8 p.m. and ending Tuesday at 6 a.m.), workers using an EVV (electronic visit verification) system should check in and check out at the beginning and end of a shift as they normally would.

Visits Lasting Longer Than 24 Hours

The DHS (Wisconsin Department of Health Services) EVV system will automatically check out a worker after 25 hours. For this reason, visits that last longer than 25 continuous hours will require a worker to check in again to continue the visit.

Alternate EVV systems may not be subject to these limitations. Providers using an alternate EVV system should seek guidance from their EVV vendor.

Topic #22860

Power Outage and Electronic Visit Verification System Outage Policy

For claims for visits that occurred during a power or system outage lasting more than 24 hours, providers may do one of the following:

- Manually enter EVV (electronic visit verification) visit information.
- Use the UC modifier on detail lines for visits without EVV information. The UC modifier will allow the claim to bypass the EVV claim edits and be paid even though there is no corresponding EVV information associated to it.

Providers must be able to show proof of an outage upon request. All other policies and documentation requirements, including billing, record of care, and timesheets, remain in effect.

A power outage is defined as a utility failure where electricity or telephone service is unexpectedly unavailable. Acceptable proof of a power outage may include documentation from the local utility company or from a publicly available database.

An EVV system outage is defined as any widespread technological failure that prevents multiple workers from using the collection methods available with their EVV system. This policy applies both to Sandata and to alternate EVV systems. A record of Sandata

outages can be found on the DHS (Wisconsin Department of Health Services) EVV home page. Providers using alternate EVV should contact their alternate EVV system vendor for proof of outages.

Topic #21817

Rounding Policies

When calculating units from data collected using EVV (electronic visit verification), the EVV system uses the same rounding logic required for providers per ForwardHealth policy. For example, for all services provided to a member (for the same billing provider) on a particular day (regardless of the number of workers assisting the member) the time is summed and rounded to the nearest unit for billing the DOS (date of service). Refer to Billing for Personal Care Services Provided and Units of Service in the Personal Care service area for more information on personal care services unit rounding. Refer to the Units of Service topic in the Home Health service area for more information about private duty nursing unit rounding. As a reminder, the number of units billed for the week should not exceed the units/minutes of care provided or authorized.

Topic #22857

Span Billing

Span billing is when one claim detail is submitted for services given over multiple consecutive days. DHS (the Wisconsin Department of Health Services) requires that certain conditions be met in order for claims using span billing to be processed correctly. This is especially important when billing for services that require EVV (electronic visit verification) information, because the units of service captured using an EVV system must be equal to or greater than the units of service billed on the claim.

To be compliant with existing DHS span billing policy, the procedure code, revenue code, modifier, and units billed must all be the same for each date included in the date span. Unless the billed units for every day in the date span are identical, providers should bill each DOS (date of service) as a separate claim detail to avoid denials.

When processing claims using span billing, DHS calculates the units billed per day by dividing the total units in the date span by the number of days in the span. The result is the calculated units for every day of the span.

DHS policy requires that, for each day in the span, there be at least as many EVV units as calculated units.

For example, if a provider bills 15 units for three days as a single claim detail, there must be at least five EVV units for each of the three days in the date span. If the EVV units were captured as six units on Monday, five units on Tuesday, and four units on Wednesday, the date span detail would not be compliant with DHS policy because Wednesday does not have at least five EVV units. Therefore, the entire claim detail for the three days would be denied.

Providers should check with their HMO or MCO (managed care organization) to confirm their span billing policy.

EVV System Technology and Use

Topic #23517

Adding Required Electronic Visit Verification Information to the Sandata Portal

In order for workers to check in and out of a visit using the Sandata EVV (electronic visit verification) system, the member must be listed as a client in the provider's Sandata EVV portal. Typically, the Sandata system automatically enters member information into the Sandata EVV portal based on an approved PA (prior authorization) or service authorization. In some instances, members who receive home health care services may not require a PA or service authorization. In other instances, the member needs care urgently, before a PA can be set up. Without an authorization, the Sandata system cannot capture EVV visits without error. Therefore, DHS (the Wisconsin Department of Health Services) allows providers to enter the required authorization information in the Sandata EVV portal when necessary.

Providers using alternate EVV should contact their vendor for information on how to add required authorization information.

Entering the required authorization information does not actually authorize a member to receive Medicaid services, nor does it create a true authorization in the ForwardHealth, HMO, or MCO (managed care organization) systems. This solution only creates the required information in Sandata to allow visits to be captured in the absence of a payer's PA or service authorization.

Topic #21837

Alternate EVV Systems

An alternate EVV (electronic visit verification) system is an EVV data collection system that is not provided by DHS (the Wisconsin Department of Health Services). Providers can choose to use either the DHS-provided Sandata EVV system or an alternate EVV data collection system.

Providers who choose to use an alternate EVV system must complete the alternate EVV certification process. The steps and amount of time needed in the certification process will depend on the alternate EVV system selected and whether Sandata has already certified the EVV vendor for use in Wisconsin. The certification and set-up process may take up to three months to complete.

Topic #23518

Sandata-Required Authorization Information for Private Duty Nursing

When a member receives PDN (private duty nursing) services (S9123, S9124, or 99504) from more than one provider, PA (prior authorization) information will only be automatically loaded to the PAL's (prior authorization liaison) Sandata account.

Therefore, any independent nurse who is not the PAL will need to manually enter authorization information in their Sandata EVV (electronic visit verification) portal to capture EVV information for that member. This only needs to be done once per member, as long as the service code the provider is authorized to provide remains the same and the end date in the Sandata EVV portal has

not yet passed.

Topic #21878

The Wisconsin Department of Health Services' EVV System

DHS's (the Wisconsin Department of Health Services) chosen EVV (electronic visit verification) solution, offered through a vendor called Sandata, may be used by all DHS programs, providers, and program payers. DHS provides the Sandata EVV system's functionality free of charge to providers and program payers. Providers and program payers do not have to purchase an EVV system if they elect to use the DHS-provided EVV system. Sandata's collection technologies are available in multiple languages for both workers and members.

For the DHS EVV system, a worker uses one of three EVV technologies to collect information at the beginning and end of each visit: the SMC (Sandata Mobile Connect) app, TVV (telephonic visit verification), or FVV (fixed visit verification).

Note: Different data collection technologies can be used to check in and out of the same visit. For example, if a worker checks in to a visit using the SMC app but finds that their phone's battery has died by the end of the visit, they could check out using TVV via the member's landline or fixed VoIP (Voice over Internet Protocol) home phone.

Mobile Visit Verification With the Sandata Mobile Connect App

The preferred method of visit data collection is through the SMC mobile app available for Android or iOS. This application collects data with or without an internet connection at the time the service is provided. The SMC app can be used on a smartphone or tablet. This app captures the required data and stores the data securely. When the worker later logs in and connects to the internet, the SMC app transmits the collected visit information. The SMC app uses the GPS to capture location information only at the start and end of a visit.

Telephonic Visit Verification

TVV uses automatic number identification technology to collect visit location information. TVV confirms the location of the landline or fixed VoIP phone in the same way the 911 system does. For this reason, a landline or fixed VoIP phone (not a smartphone) must be used to call in to the Sandata EVV system. The member's home landline or fixed VoIP phone number is associated with the member in the Sandata system.

Fixed Visit Verification

FVV uses a small electronic device that is attached to a surface in the home and generates codes containing visit data. The FVV device captures the EVV visit, but doesn't report the EVV visit information. Instead, the worker has to make note of the check in and check out codes generated by the device and then call them in to a TVV line when they have access to a phone.

FVV devices are the data collection method of last resort. A device should only be requested by the provider if services are anticipated to be authorized for more than 60 days and all the following criteria are met:

- The member does not have a landline or fixed VoIP home phone.
- The worker does not have a smartphone or tablet that would support the SMC app.
- The member does not have a smartphone or tablet that would support the SMC app.
- The member has a smartphone or tablet, but it is not available for EVV purposes.

Providers may request a device through the Sandata EVV portal. The provider will be required to attest that the situation meets

the above criteria and that the device will remain in the home of the member. Devices will be sent directly to the member's home address with instructions for the member and the worker. The device must be affixed to a surface within the member's home. One device is needed per member, per provider.

The following FVV criteria may also apply:

- If a member is receiving EVV services from more than one provider, the member will need a device for each provider.
- If a member changes providers, a new device must be requested for the new member and provider combination.
- If the member moves to a new home, the member should take the device to the new home if they will not be changing their provider.

Devices must be returned to Sandata if the worker has access to another EVV method, the member is no longer authorized to receive services, or the provider is no longer authorized to provide the services. To return the device, the provider agency should contact Wisconsin EVV Customer Care. Customer Care will send a return package directly to the member's home. DHS will monitor the usage of devices. If the device is not used for three months, DHS will request the return of the device.

If a device is lost, stolen, or damaged, the provider should contact Wisconsin EVV Customer Care to request a new device. A replacement device will be issued from Sandata. Until the replacement device is received, the provider will need to manually enter the EVV data and keep records that support the need for manual entry.

DHS OIG (Office of the Inspector General) monitors the use of FVV devices.

EVV Data Submission Hardware and Services

Hardware and services for submitting data to the DHS-provided Sandata EVV system must be provided by the provider, worker, or member, with the exception of the device used in FVV. Depending on the technology used, hardware and services may include:

- Smartphones
- Tablets
- Cell service
- Wi-Fi
- Data use
- Landline or fixed VoIP phones
- Landline or fixed VoIP phone service

DHS recognizes that access to technology in the homes of members varies across the state. The methods used by the DHS-provided Sandata EVV system to collect visit data do not require cell or Wi-Fi service at the time of service. The provider, worker, and member can choose the technology that is best suited to the member's needs and local conditions.

In some cases, the hardware and services may already be present at the service location. DHS encourages providers to work on agreeable arrangements with workers and members for use of these resources where available.

Providers and program payers should consult with an attorney for specific labor law questions regarding employee use of resources.

Coverage of a device or internet service for EVV purposes is not reimbursable under any program.

DHS also uses the Sandata aggregator, a technology that allows an alternate EVV system (for example, a system not provided by DHS) to connect with DHS. Alternate EVV systems send a provider's EVV visit information to the Sandata aggregator where providers can verify EVV visit information was received and that visits are in a verified status. The Sandata aggregator feeds all EVV visit information to DHS. DHS processes the visits and sends files to payers on a daily basis.

General EVV Information

Topic #21757

An Overview

EVV (electronic visit verification) uses technology to make sure that members receive the services they need. Workers check in at the beginning and check out at the end of each visit, using a smartphone or tablet, landline or fixed VoIP (Voice over Internet Protocol) phone, or fixed device. The EVV system captures six key pieces of information:

- Who receives the service.
- Who provides the service.
- What service is provided.
- Where the service is provided.
- The date of the service.
- The time the service begins and ends.

Topic #21917

Home Health

For home health providers who provide personal care services, refer to the Electronic Visit Verification section of the Personal Care service area of the Online Handbook.

Topic #23137

Home Health Service Codes

Workers providing Medicaid-covered home health services are required to use an EVV (electronic visit verification) system. Specifically, impacted services are those billed under the following procedure codes:

- 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual [per visit])
- 97139 (Unlisted therapeutic procedure [specify] [per visit])
- 97799 (Unlisted physical medicine/rehabilitation service or procedure [per visit])
- 99504 (Home visit for mechanical ventilation care [per hour])
- S9123 (Nursing care, in the home; by registered nurse, per hour)
- S9124 (Nursing care, in the home; by licensed practical nurse, per hour)
- 99600 (Unlisted home visit service or procedure [per visit])
- T1001 (Nursing assessment/evaluation [per visit])
- T1021 (Home health aide or certified nurse assistant, per visit)
- T1502 (Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit)

Provider Agency and Worker Identification

Topic #23138

Home Health Care Live-In Workers

DHS (the Wisconsin Department of Health Services) requires all workers, including live-in workers, to capture EVV (electronic visit verification) information for all HHCS (home health care services) codes.

Topic #21857

Provider Agency Identification Numbers

For EVV (electronic visit verification) visit information to be correctly associated to claims and encounters, DHS (the Wisconsin Department of Health Services) requires all providers to have a Medicaid provider ID number regardless of the EVV system used.

DHS will associate EVV claims and encounters to Medicaid-enrolled providers using their Medicaid ID. In addition to having a unique Medicaid provider ID, providers of EVV services must also have a unique ID for each worker.

Providers may use their NPI (national provider identifier) for authorization and billing.

Note: In-state and out-of-state providers must be enrolled through either the Medicaid/Border Status Provider Enrollment or the Medicaid In-State Emergency/Out-of-State Enrollment application on the ForwardHealth Portal.

Topic #21797

Worker Identification Numbers

Every worker who provides personal care or home health care services is required to have a unique worker ID number from the ForwardHealth Portal, regardless of which EVV (electronic visit verification) system they use. Independent nurses are considered both workers and providers, and are required to have both IDs.

Workers are assigned one ID that can be used to associate them to multiple providers. Providers are required to maintain worker information, including disassociating workers who no longer work with the agency. Providers may refer to the Electronic Visit Verification Portal Functionality User Guide for instructions on associating, maintaining, and disassociating worker IDs. It is the responsibility of each provider to use the secure ForwardHealth Portal to maintain an accurate and complete list of workers who provide EVV services to members.

Resources

Topic #21877

Wisconsin EVV Customer Care and Other Resources

Wisconsin EVV (electronic visit verification) Customer Care is a call center devoted solely to supporting EVV. Providers, program administrators, program payers, members, and workers may receive support from this contact center.

Wisconsin EVV Customer Care manages all EVV-related program and technical calls, including those related to implementation and ongoing operations. Provider Services manages calls about provider enrollment with Medicaid. Enrollment-related questions, including questions about enrolling with EVV-related provider specialties or services, should be directed to Provider Services.

EVV Customer Care
Email support: VDXC.ContactEVV@wisconsin.gov
Phone support: 833-931-2035
Hours of operation: Monday–Friday, 7 a.m. to 6 p.m. CT

More information about EVV:

EVV webpage
EVV FAQs
Electronic Visit Verification Portal Functionality User Guide
Training resources

Verification and Validation of Data

Topic #21858

Data Corrections

Administrative users of the DHS (Wisconsin Department of Health Services)-provided Sandata EVV (electronic visit verification) system may correct exceptions (errors or omissions) to EVV data. In the DHS-provided Sandata EVV system, providers can log into the Sandata EVV portal to identify exceptions that are preventing visit data from being verified. The administrator can acknowledge or correct these exceptions to move the visit into a verified status. Only verified visits are later matched with claims.

All corrections to EVV visit information, including those made through an alternate EVV system, require an associated reason code to explain why the EVV data was created or changed. Corrections applied to the EVV data are monitored by DHS. The provider must retain and maintain documentation of the reason for the correction, per CMS (Centers for Medicare & Medicaid Services). DHS OIG (Office of the Inspector General) monitors corrected exceptions for valid EVV data.

Topic #21860

Data Validation

Once an EVV (electronic visit verification) visit is in a verified status, the provider or program payer can submit the claim or encounter. DHS (the Wisconsin Department of Health Services) then systematically matches claim or encounter data to EVV data to ensure that each service has corresponding EVV data to support payment. This process is called validation.

The following claim information is compared to the EVV data:

- Member ID
- Provider ID
- Service Code
- DOS (date of service)
- Billed units

Topic #23018

Communication About Missing Information

For providers billing fee-for-service Medicaid, ForwardHealth uses EOB (explanation of benefits) messages to indicate EVV information that is missing, is inadequate, or does not meet the required matching criteria. Providers should review these EOB messages for information on errors that need to be corrected.

Topic #21859

Data Verification

Providers and program payers are responsible for ensuring EVV (electronic visit verification) data is collected and in a verified status prior to a claim or encounter being submitted. All visits must be in a verified status before Sandata sends the visit information to DHS (the Wisconsin Department of Health Services).

Services are considered verified by the DHS EVV system when all the following information is captured:

- Who received the service
- Who provided the service
- What service was provided
- The date of the service
- The time the service begins and ends

To assist with data verification, providers and program payers using the DHS-provided Sandata EVV system must assign administrative users to the Sandata EVV portal. Administrative users can make manual edits to add or modify visit data if information is missing or inaccurate.

Topic #21861

Manual Time Entry

All EVV (electronic visit verification) services are required to have complete EVV data in order to be in a verified status. In the circumstance that a visit was not electronically captured at the time of the visit, such as with member retroactive enrollment, the provider may manually enter the visit information. For the DHS (Wisconsin Department of Health Services)-provided EVV system, providers enter this information using the Sandata EVV portal. Providers using an alternate EVV system should check with their vendor on how to manually capture a visit.

Manually entered visits should only be used when absolutely necessary. All manually entered visits require an associated reason code. The provider must retain and maintain documentation of the reason for the manual entry. DHS OIG (Office of the Inspector General) monitors manually entered visits.

Managed Care

5

Archive Date:08/03/2026

Managed Care:Claims

Topic #384

Appeals to BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs

BadgerCare Plus/Medicaid SSI HMO and Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) contracted and non-contracted providers are required to first file an appeal directly with the HMO/PIHP after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO/PIHP or the HMO's/PIHP's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO/PIHP may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO/PIHP within the time frame established by the HMO/PIHP. Special care should be taken to ensure the documents reach the HMO/PIHP by the timely, filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, secure Portal, fax, certified mail, or secure email).

The HMO/PIHP has 45 calendar days to respond in writing to a formal appeal. The HMO/PIHP decides whether to pay the claim and sends a letter stating this decision. If the HMO/PIHP does not respond in writing within 45 calendar days or the provider is dissatisfied with the HMO's/PIHP's response, the provider may submit an appeal to ForwardHealth through the Provider Appeals portal within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO/PIHP response.

Topic #385

Appeals to ForwardHealth

ForwardHealth **will not review** appeals that were not first made to the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO/PIHP, the appeal will be returned to the provider., and the payment denial or reduction will be upheld.

The provider has 60 calendar days to file an appeal with ForwardHealth after the HMO/PIHP either does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO/PIHP response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in an HMO/PIHP on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the HMO/PIHP will be notified by ForwardHealth of the final decision. If the decision is in the provider's favor, the HMO/PIHP is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal to ForwardHealth through the Provider Appeals portal.

How to Begin Using the Provider Appeals Portal

Providers who contract with a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP and who need to appeal a claim decision will be required to register and set up a Provider Appeals portal account. Note: This portal account is separate from a provider's secure ForwardHealth Portal account.

To register for a Provider Appeals portal account, providers and HMOs/PIHPs can access the Provider Appeals portal. Providers are required to complete and submit the registration form, available by clicking either the HMO Registration or Provider Registration button (as applicable) on the Provider Appeals portal home page. Examples of information required to complete the registration process include the following:

- The provider's Medicaid ID or both their NPI (National Provider Identifier) and taxonomy code
- Provider ZIP+4 code
- DOS for the appeal
- Contact information (name, email, phone number) for the person registering

Once ForwardHealth receives and processes the registration form, an account login ID and associated PIN (provider identification number) will be created. Providers will receive an email message with their Provider Appeals portal login ID and will receive their PIN information in a mailed letter.

Note: Third party administrators and out-of-state providers must call the EDI (Electronic Data Interchange) Helpdesk at 866-417-4979 or send an email to vedswiedi@wisconsin.gov to begin registration.

More information on registering for and using the Provider Appeals portal and additional portal resources, including the Provider Appeals Portal User Guide, is available.

Portal Functionality

Providers can use the ForwardHealth appeals process through the Provider Appeals portal after exhausting the HMO/PIHP payment dispute process. Providers are required to use the Provider Appeals portal to:

- Submit an appeal to ForwardHealth for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP claim payment denial or reduced payment.
- Submit documentation.
- Check the status of an appeal.
- Respond to requests for additional information.
- View decision notices.

For assistance regarding submission of an appeal through the ForwardHealth Portal, providers can call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Required Documentation

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- The provider's written appeal to the HMO/PIHP
- The HMO's/PIHP's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)

- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included.

Appeal Decisions

A decision to uphold the HMO's/PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted to ForwardHealth for review. Failure to submit the required documentation or submitting incomplete, insufficient, or illegible documentation may lead to the original denial being upheld. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation.

If the HMO/PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted, providers must contact the ForwardHealth Managed Care Unit at 800-760-0001, option 1, and request that the appeal be withdrawn.

To check on the status of an appeal submitted to ForwardHealth, providers can:

- Access the Provider Appeals portal.
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Topic #386

Claims Submission

BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs (Prepaid Inpatient Health Plans) have requirements for timely filing of claims, and providers are required to follow the HMO/PIHP claims submission guidelines for each organization. Providers should contact the enrollee's HMO/PIHP for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) enrollee that have been denied by an HMO/PIHP but may be paid as fee-for-service claims.

These are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO/PIHP at the time they were admitted to an inpatient hospital, but then they enrolled in an HMO/PIHP during the hospital stay. In this case, all claims related to the stay (including professional claims) should be submitted to fee for service. For the professional claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).
- The claims are for orthodontia/prosthodontia services that began before HMO/PIHP coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must include:

- A legible copy of the completed claim form in accordance with billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.
- A copy of the Explanation of Medical Benefits form as applicable.

Submit extraordinary claims to:

ForwardHealth
Extraordinary Claims
313 Blettner Blvd
Madison WI 53784

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). Before submitting claims to HMOs/PIHPs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's HMO/PIHP for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) denies a provider's claim, the HMO/PIHP is required to send the provider a notice informing them of the right to file an appeal.

An HMO/PIHP network or non-network provider may file an appeal to the HMO/PIHP when:

- A claim submitted to the HMO/PIHP is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO/PIHP **before** filing an appeal with ForwardHealth.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment
- Chiropractic services
- CRS (Community Recovery Services)
- CSP (Community Support Programs)
- CCS (Comprehensive Community Services)
- Crisis intervention services
- Directly observed therapy for individuals with tuberculosis
- MTM (Medication therapy management)
- NEMT (Non-emergency medical transportation) services
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- Physician-administered drugs and their administration
- SBS (School-based services)
- Targeted case management

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP
- CCS
- Crisis intervention services
- SBS
- Targeted case management services

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Topic #390

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental
- Chiropractic

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

The following services are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to members on a fee-for-service basis as long as ForwardHealth covers the service for the member, and the service is medically necessary:

- Behavioral treatment services (for example, autism services)
- Chiropractic services, unless the HMO elects to provide chiropractic services
- County-based mental health programs, including CCS (comprehensive community services), CRS (Community Recovery Services), CSP (community support program) benefits, and crisis intervention services
- Dental

  Note: HMOs must provide dental services in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.

- Environmental lead investigation services provided through local health departments
- Hub and Spoke Health Home or SUD (substance use disorder) pilot programs (integrated recovery support services)
- Medication therapy management
- Pharmacy services and diabetic supplies
- PNCC (Prenatal care coordination) services
- Physician-administered drugs

  Note: The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

- Residential SUD treatment
- SBS (School-based services)
- Targeted case management services
- NEMT (Non-emergency medical transportation) services
- DOT (Directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers who render any of these services to a BadgerCare Plus or Medicaid SSI HMO member should submit PA (prior authorization) requests and claims directly to ForwardHealth for coverage.

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with BadgerCare Plus HMO or SSI HMOs. For example, in certain circumstances, members seeing a specialist when they are enrolled in an HMO **may** qualify for an exemption if their specialty provider is not in the HMO networks.

The contracts between Wisconsin DHS (Department of Health Services) and the HMOs provide more detail on the exemption and disenrollment requirements.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage may be verified by using Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older who meet the SSI and SSI-related disability criteria
- Dual eligibles for Medicare and Medicaid

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide

contact information. Once enrolled in a BadgerCare Plus HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits
- Telephone and face-to-face support
- Assistance with enrollment, disenrollment, and exemption procedures

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.

- Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #393

Member Grievances

Members have the right to file a grievance with their HMO if they are unsatisfied with the services of the HMO or its providers. A member can file a grievance at any time for issues like:

- Service quality.
- Disrespect from a provider or an employee.
- Violations of their member rights.

Members should contact the Wisconsin HMO Ombudsman Program to help solve the problem or write a formal grievance to the HMO. The SSI External Advocate can help SSI HMO members with filing a grievance.

Topic #396

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has specific standards regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary, and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by MC in the EB01, HM in the EB04, and Care4Kids in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at 800-482-8010 for the following:

- To become part of the CCHP network
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Topic #402

Managed Care Contracts

The contract between the Wisconsin DHS (Department of Health Services) and the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs or PIHPs. If there is a conflict, the HMO or PIHP contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and PIHP contracts are available on the Acute and Primary Managed Care page (click the HMO Providers link, then the Resources and Help tab) for HMOs and on the Children's Specialty Programs page of the ForwardHealth Portal (click the Children's Specialty Managed Care Plans link, then the Policy tab) for PIHPs.

Topic #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term care) programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (for example, medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related Medicaid members may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- Members under 19 years of age
- Members of a federally recognized tribe
- Dual eligible members
- MAPP (Medicaid Purchase Plan) eligible members
- Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 90 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA (prior authorization) that is currently approved by ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- An initial health assessment
- A comprehensive care plan
- Assistance in choosing providers and identifying a primary care provider
- Assistance in accessing social and community services
- Information about health education programs, treatment options, and follow-up procedures
- Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

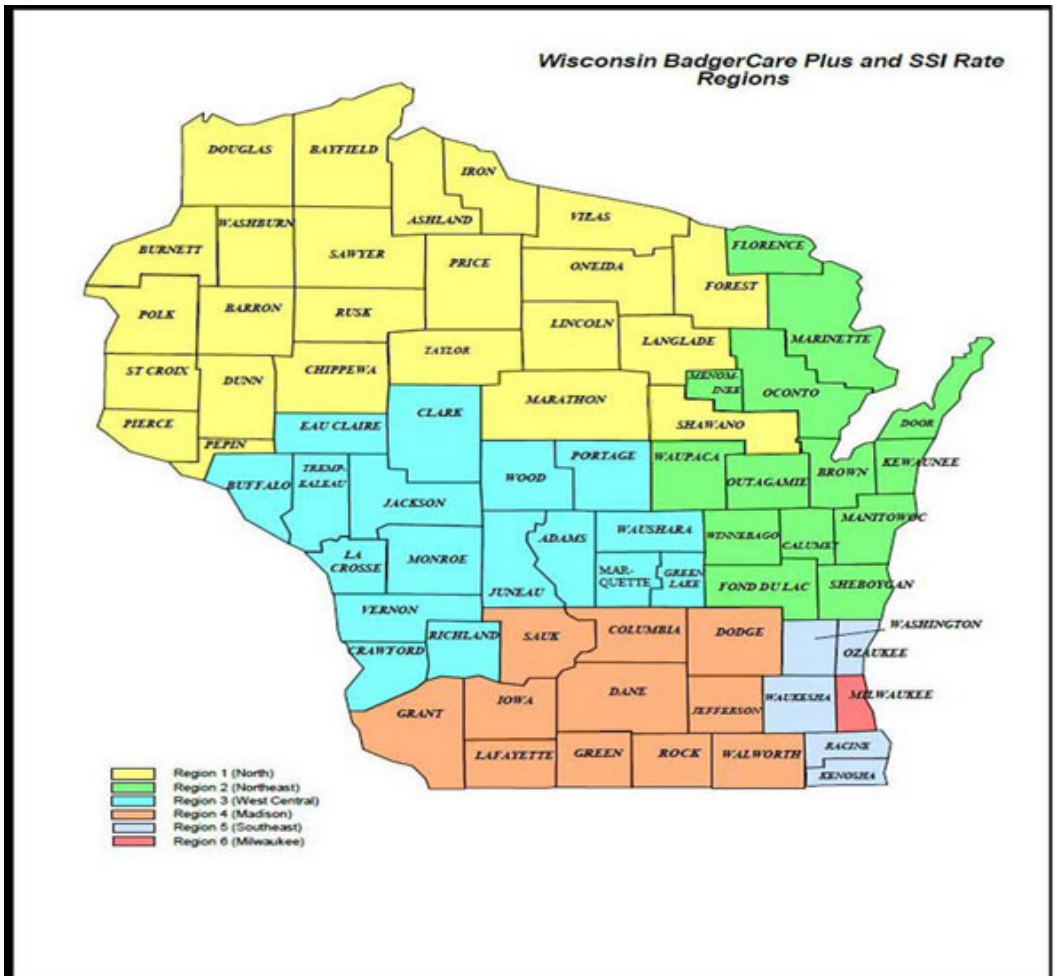
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

SSI Rate Regions


Wisconsin BadgerCare Plus and SSI Rate Regions
DOUGLAS
BAYFIELD
IRON
ASHLAND
VILAS
WASHBURN
BURNETT
SAWYER
PRICE
ONEIDA
FLORENCE
FOREST
POLK
BARRON
RUSK
LINCOLN
LANGLADE
MARINETTE
ST CROIX
DUNN
CHIPPEWA
TAYLOR
MENOM-INEE
OCONTO
PIERCE
EAU CLAIRE
CLARK
MARATHON
SHAWANO
DOOR
PEPIN
TREMP-EALEAU
WOOD
PORTAGE
WAUPACA
OUTAGAMIE
BROWN
KEWAUNEE
BUFFALO
JACKSON
WAUSHARA
WINNEBAGO
MANITOWOC
ADAMS
CALUMET
LA CROSSE
MONROE
MAR-QUETTE
GREEN LAKE
FOND DU LAC
SHEBOYGAN
JUNEAU
VERNON
RICHLAND
SAUK
COLUMBIA
DODGE
WASHINGTON
CRAWFORD
OZAUKEE
IOWA
DANE
WAUKESHA
MILWAUKEE
GRANT
JEFFERSON
LAFAYETTE
GREEN
ROCK
WALWORTH
RACINE
KENOSHA
Region 1 (North)
Region 2 (Northeast)
Region 3 (West Central)
Region 4 (Madison)
Region 5 (Southeast)
Region 6 (Milwaukee)

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA (prior authorization) guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Provider Information

Topic #406

Copays

Providers cannot charge Medicaid SSI HMO enrollees copays for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. However, even in these cases, providers are prohibited from collecting copay from members who are exempt from the copay requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copays will apply, except when the member or the service is exempt from the copay requirement.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 C.F.R. § 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #408

Non-Network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services)

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider but must provide access to Medicaid-covered, medically necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

6

Archive Date:08/03/2026

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100% of the FPL (Federal Poverty Level).
- Pregnant women with incomes at or below 300% of the FPL.
- Children (ages 18 and younger) with household incomes at or below 300% of the FPL.
- Childless adults with incomes at or below 100% of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100% of the FPL.

Where available, BadgerCare Plus members are enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Premiums

The following members are required to pay premiums to be enrolled in BadgerCare Plus:

- Transitional medical assistance individuals with incomes over 133% of the FPL. Transitional medical assistance individuals with incomes between 100 and 133% FPL are exempt from premiums for the first six months of their eligibility period.
- Children (ages 18 and younger) with household incomes greater than 200% with the following exceptions:
  - Children under age 1 year.
  - Children who are tribal members or otherwise eligible to receive Indian Health Services.

Topic #16677

BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- BadgerCare Plus Benchmark Plan
- BadgerCare Plus Core Plan
- BadgerCare Plus Basic Plan

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the March 2014 Online Handbook archive of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Plus Prenatal Program is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable **only** if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for **all** covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate income maintenance or tribal agency where they can apply for this coverage.

Fee for Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (for example, claim submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (for example, a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #2757

Birth to 3 Program

A child from birth up to (but not including) age three is eligible for Birth to 3 services if the child meets one of the following criteria:

- The individual has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- The individual has at least a 25% delay in one or more of the following areas of development:
  - Cognitive development
  - Physical development, including vision and hearing
  - Communication skills
  - Social or emotional development
  - Adaptive development, which includes self-help skills
- Atypical development affecting the child's overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

ForwardHealth provides Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus/Medicaid members.

There are certain referral requirements for therapy providers to encourage service coordination with the Birth to 3 Program.

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the income maintenance or tribal agency.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (for example, PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (for example, mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive management or related services.

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

Providers should inform members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and web services, including:

- BadgerCare Plus
- BadgerCare Plus and Medicaid managed care programs
- SeniorCare
- HDAP (Wisconsin HIV Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WIR (Wisconsin Immunization Registry)
- Wisconsin Medicaid
- Wisconsin Well Woman Medicaid
- WWWP (Wisconsin Well Woman Program)

ForwardHealth interChange is supported by the state's fiscal agent, Gainwell Technologies.

Topic #229

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying for Family Planning Only Services
- QDWI (Qualified Disabled Working Individuals)
- QI-1 (Qualifying Individuals 1)
- QMB Only (Qualified Medicare Beneficiary Only)
- SLMB (Specified Low-Income Medicare Beneficiary)
- Tuberculosis-Related Medicaid

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

Topic #228

Medicaid

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 (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in Wis. Stat. ch. 49.

Wisconsin Medicaid enrollment 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 enrolled in Wisconsin Medicaid if they are in one of the following categories:

- Age 65 and older
- Blind
- Disabled

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

- Katie Beckett
- Medicaid Purchase Plan
- Foster care or adoption assistance programs
- SSI (Supplemental Security Income)
- WWWP (Wisconsin Well Woman Program)

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

- Income maintenance or tribal agencies
- Medicaid outstation sites
- SSA (Social Security Administration) offices

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

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

(managed care organizations).

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their income maintenance or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiary)

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They receive payment of the following:

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

QMB-Only members are certified by their income maintenance or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 1) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their income maintenance or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an applicant is determined eligible through the real-time eligibility process, they are considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

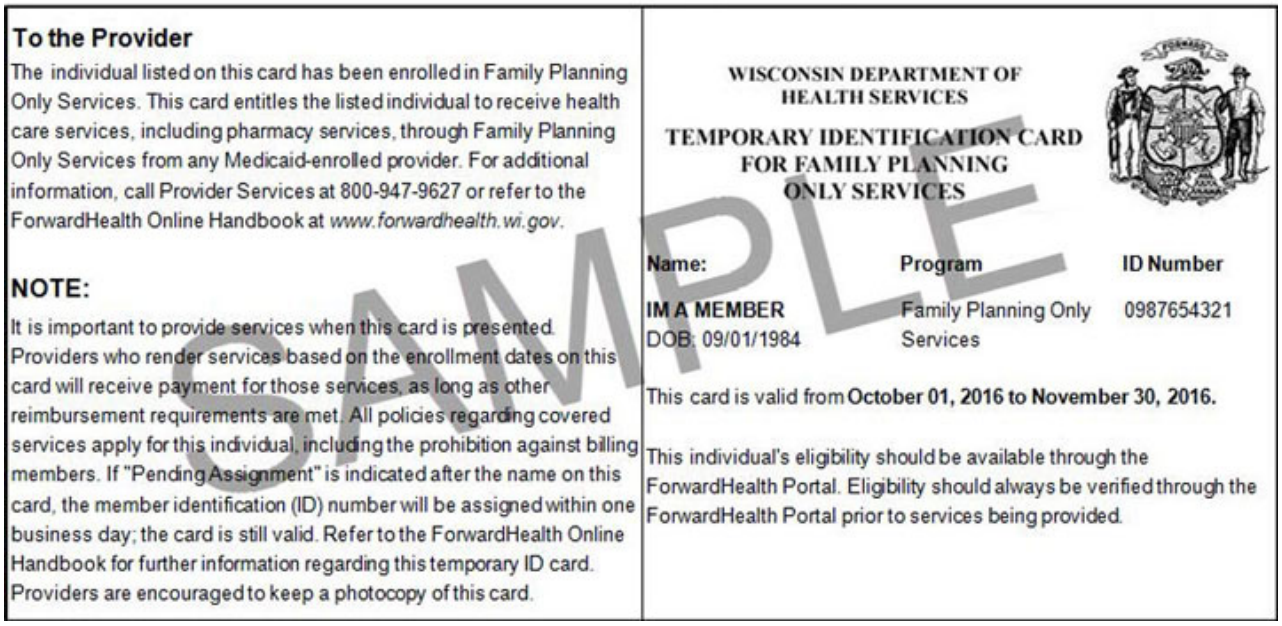
TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	BadgerCare Plus	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

Sample Temporary Identification Card for Family Planning Only Services



To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

SAMPLE

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their income maintenance or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120% of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #262

Tuberculosis-Related Medicaid

Tuberculosis-Related Medicaid is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

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 WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment 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 enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some 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 member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will **not** reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

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

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage **prior to** each DOS (date of service) that services are provided. Pursuant to Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before

receiving services.

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

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets their ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members 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 members who are over 65 years of age, blind, or disabled

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program) enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA (Division of Hearings and Appeals).

Pursuant to Wis. Admin. Code § HA 3.03, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that 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 BadgerCare Plus, HDAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, HDAP, or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

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

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

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing (DHA-28 (08/09)) form.

Claims for Appeal Reversals

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

If a provider has not yet submitted a claim, 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.

Claim Denial Due to Termination of HDAP Enrollment

If a claim is denied due to termination of HDAP enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
HDAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to HDAP Claims and Adjustments.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

Members may receive covered services from **any** willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted MCO (managed care organization) or assigned to the Pharmacy Services Lock-In Program.

Topic #248

General Information

Members are entitled to certain rights per Wis. Admin. Code ch. DHS 103.

Topic #250

Notification of Discontinued Benefits

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

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment 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.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Identification Cards

Topic #266

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

Digital ForwardHealth Identification Cards

Members can access digital versions of their ForwardHealth cards on the MyACCESS mobile app. Members are able to save PDFs and print out paper copies of their cards from the app. The digital and paper printout versions of the cards are identical to the physical cards for the purposes of accessing Medicaid-covered services. All policies that apply to the physical cards mailed by ForwardHealth to the member also apply to the digital or printed versions that members may present.

A member may still access their digital ForwardHealth card on the MyACCESS app when they are no longer enrolled. The MyACCESS app will display a banner message noting that the member is not currently enrolled in a ForwardHealth program. Providers should always verify enrollment with Wisconsin's EVS.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on their ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

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

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use

the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if they do not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, they may call Member Services to request a new one.

If a member lost their ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

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

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (for example, white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (for example, paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in Wis. Admin. Code § DHS 104.02(5).

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service
- Not seeking duplicate care from more than one provider for the same or similar condition
- Not seeking medical care that is excessive or not medically necessary

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (that is, due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (for example, home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids
- Barbiturates used for seizure control
- Lyrica
- Provigil and Nuvigil
- Weight loss drugs

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by Acentra. Acentra may be contacted by phone at 877-719-3123, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Acentra
PO Box 3570
Auburn AL 36831-3570

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The lock-in prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using their professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (02/2025)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the lock-in prescriber may also contact the lock-in pharmacy to give the pharmacist (s) guidelines as to which medications should be filled for the member and from whom. The primary lock-in prescriber should also coordinate the provision of medications with any other prescribers they have designated for the member.

The lock-in pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their lock-in prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary lock-in prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless they have been designated by the lock-in prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than their lock-in prescriber or lock-in pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary lock-in prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-lock-in prescriber to the designated lock-in pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated lock-in prescriber, alternate prescriber, lock-in pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the prescription is not

from a designated lock-in prescriber, the lock-in pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the lock-in pharmacy provider may contact the lock-in prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the lock-in pharmacy provider may do one of the following:

- Speak to the member.
- Call Acentra.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated lock-in prescriber, alternate lock-in prescriber, lock-in pharmacy, or alternate lock-in pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

For More Information

Providers may call Acentra with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members
- A member's enrollment in the Pharmacy Services Lock-In Program
- A member's designated lock-in prescriber or lock-in pharmacy

Topic #273

Providers May Refuse to Provide Services

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

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth 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 ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Topic #23277

12-Month Continuous Health Care Coverage for Children

Most children enrolled in BadgerCare Plus or Medicaid programs will keep their health insurance coverage for 12 months. Even if their family has a change in income or other circumstances, children under age 19 will have coverage at least until their next renewal. This policy is required by the federal Consolidated Appropriations Act, 2023.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- BadgerCare Plus
- Emergency Services Medicaid
- Family Planning Only Services
- Foster Care Medicaid
- HCBW (Home and Community-Based Waiver) Medicaid
- Institutional Medicaid
- Katie Beckett Medicaid
- MAPP (Medicaid Purchase Plan)
- Medicare Savings Programs
- Special Status Medicaid
- SSI (Supplemental Security Income)-Related Medicaid
- SSI Medicaid
- Tuberculosis-Related Medicaid
- Wisconsin Well Woman Medicaid

Exceptions to Continuous Coverage

Continuous coverage does not apply to children:

- Enrolled under presumptive eligibility, also known as Express Enrollment.
- Enrolled by meeting a deductible. These are members who become eligible for up to a six-month period based on their medical expenses.

Children remain eligible for the 12 months until their next renewal unless:

- They turn 19.
- They move out of Wisconsin.
- Their citizenship or immigration status is not verified.
- Their eligibility was based on inaccurate information or agency error.
- The family asks to end their coverage.

Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS (Department of Health Services).

Member Resources

Free Health Insurance Application and Renewal Assistance

Members who need help with applying for or renewing health care coverage can access the following resources:

- Covering Wisconsin (free expert help with health insurance), available at the WisCovered website
- 211 Wisconsin at 211 or 877-947-2211

Continuous Coverage and Health Care Renewal Information

Additional member resources regarding health care renewals and continuous coverage for children are available:

- Medicaid: Programs for Children web page
- Health Care Renewals web page
- "Keeping Kids Covered" 12-Month Continuous Coverage for Children fact sheet
- BadgerCare Plus: Frequently Asked Questions

Additional policy information on continuous coverage for children is available in the BadgerCare Plus Handbook.

Topic #276

Medicaid Members From Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

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

- An emergency illness or accident
- When the member's health would be endangered if treatment were postponed
- When the member's health would be endangered if travel to Wisconsin were undertaken
- When PA (prior authorization) has been granted to the provider for provision of a nonemergency service
- When there are coinsurance, copay, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Travel expenses such as lodging or food are not reimbursable by Wisconsin Medicaid.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate 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 the following:

- 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, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (for example, heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, services for ESRD (end-stage renal disease) and all labor and delivery are considered emergency services.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300% of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within 10 calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer them to the income maintenance or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens (F-01162 (02/2009)) form for clients to take to the income maintenance or tribal agency in their county of residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

Note: Detained by legal process means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits and are not subject to eligibility suspension. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) or county jail oversee health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #280

Retroactive Enrollment

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

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

Reimbursing Members in Cases of Retroactive Enrollment

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

If a service(s) that requires PA (prior authorization) was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (for example, local General Relief agency) the full amount that the member paid for the service.

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

Topic #281

Spenddown to Meet Financial Enrollment Requirements

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

The certifying agency calculates the individual's 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 ForwardHealth and the provider of the last service that the individual is 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 benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (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 ForwardHealth of the individual's enrollment and identifies the following:

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

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update (F-10109 (02/2014)) form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Prior Authorization

7

Archive Date:08/03/2026

Prior Authorization:Decisions

Topic #10538

Acting as Prior Authorization Liaison

One Prior Authorization per Member

One PA (prior authorization) for PDN (private duty nursing) services may be authorized for the member, regardless of the number of providers providing PDN services to the member. All providers on the PDN case, including NIP (nurses in independent practice), HHA (home health agency), and PCC (pediatric community care) centers, will now share one PA for the member.

PDN PAs can be authorized for up to 364 days and will be divided into 13-week segments. It is important that providers refer to their PA decision notice letter for exact expiration dates.

All providers on the case are responsible for ensuring there is a current authorized PA on file for the member before providing PDN services. Each PDN provider on the case is required to obtain a copy of the PA decision notice letter(s) for their records.

Once the PA is approved for the member, Medicaid-enrolled providers can be added to the case as needed any time during the authorized time period for quick access to nursing staff for members. Although PDN services are authorized for up to 364 days, the hours of PDN services authorized for each segment can be used only in the 13-week segment for which they were authorized. In other words, hours of PDN authorized in one segment do not carry over to another segment.

Prior Authorization Liaison Defined

When more than one provider is to provide PDN services to a member, one of the providers sharing the case is required to serve as the PDN PAL (prior authorization liaison). The PAL may be an NIP, an HHA, or a PCC and will be responsible for obtaining PA for PDN services to the member. The identified PAL is the only provider who can submit PA requests, PA amendments, and respond to PA return notices.

Qualifications

For the provider to serve as the PDN PAL, the provider must provide PDN services (ventilator-dependent or non-ventilator-dependent) to the member and be one of the following:

- A Wisconsin-licensed RN (registered nurse) who is Medicaid-enrolled as a NIP
- A Wisconsin-licensed RN employed by or under contract to an HHA enrolled in Wisconsin Medicaid to provide PDN
- A Wisconsin-licensed RN employed or under contract to a Medicaid-enrolled PCC provider

Responsibilities

The following are responsibilities of the PAL:

- Submitting completed PA and amendment request documents to ForwardHealth
  - PA/RFs (Prior Authorization Request Form, F-11018 (04/2026)) completed using the PA/RF completion instructions for PDN services
  - POC (plan of care) that was developed in cooperation with the physician, member, member's family, and with any other providers who will be providing PDN services to the member
  - Private Duty Nursing Prior Authorization Acknowledgment (F-11041 (10/2008))

- Prior Authorization Amendment Request (F-11042 (07/2012)), if requesting to amend the PA
- Provider review letter in order to correct clerical errors or provide additional clinical information

- Sharing documents
  - Make available to other PDN providers on the case the PA decision notice letters to copy for their records
  - Make available to other PDN providers on the case to copy for their records the decision notice letters resulting from amendment requests
  - Make available to other PDN providers on the case the PA request and amendment request(s) for their review

Topic #424

Approved Requests

PA (Prior authorization) requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested **service**, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Topic #10317

Approved Requests for Private Duty Nursing

The PDN (private duty nursing) PAL (prior authorization liaison) receives a copy of a PA decision notice when a PA request for PDN service(s) is approved. Each PDN provider on the case is advised to carefully read decision notice letters before providing services.

Topic #10557

Changing the Prior Authorization Liaison

The actions required of the other PDN (private duty nursing) providers on the case depend on the circumstances for changing the PAL (prior authorization liaison) when the identified PAL will no longer be the PAL.

At the End of the Authorization Period

A different provider can assume the role of PDN PAL without enddating a current PA (prior authorization) when the authorization period is completed and it is time to submit a new PA request. The PDN providers on the case along with the member or member's family will be required to identify the new PAL. It is important that the arrangements for a new PAL are made in

advance to allow the new PAL adequate time to submit the PA request renewal for ongoing PDN services before the end of the current authorization period.

The Prior Authorization Liaison Remains on the Case

If the PDN PAL steps down as the PAL, but remains on the case, ForwardHealth will not adjudicate the PA amendment requests solely for the purpose of changing the PAL. There is no requirement to identify another RN (registered nurse) on the case as the PAL until there is a need to amend the current PA or until it is time to submit a new PA request for ongoing PDN services. If the PA needs to be amended (for example, as a result of a change in the member's medical condition) the PDN providers are required to follow the process described for requesting PA if the PAL leaves the case with notice.

The Prior Authorization Liaison Leaves the Case with Notice

If the PDN PAL leaves the case with notice, the following actions will be necessary to assure continuity of care:

- The PDN providers on the case, along with the member or member's family, will be required to identify a new PAL.
- The PAL leaving the case is required to submit a PA amendment request to enddate the current PA.
- The new PAL is required to submit a new PA request with the required documentation prior to the expiration of the current PA being enddated. Providers must not submit the request for a new PA before the PAL leaving the case submits the amendment. ForwardHealth will assign different grant and expiration dates to the new authorized PA.

The Prior Authorization Liaison Leaves the Case Without Notice

If the PDN PAL leaves the case without enddating the current PA, the following actions will be necessary to assure continuity of care:

- The PDN providers on the case along with the member or member's family will be required to identify a new PAL.
- The new PAL must end the current PA by submitting a paper Prior Authorization Amendment Request form by mail or fax. In addition to the member information in Section I, the amendment request must include the following detail:
  - The new PAL's provider information in Section II
  - The member's printed name and signature included on the Prior Authorization Amendment Request in Section III, Element 11 (Description and Justification for Requested Change)
  - The reason for requesting an amendment to enddate the PA in Section III
  - The requested enddate for the PA in Section III
- The new PAL then is responsible for submitting a new PA request and the PA will be assigned a new grant and expiration date. A PA for an ongoing case may be backdated up to 14 days from the first date of receipt only when the PAL leaves the case without ending the current PA.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal, as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as their PA address (or to the physical address if there is no PA address on file), **not** to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Topic #10337

Prior Authorization Decision Notice Letter for Private Duty Nursing

For PDN (private duty nursing) services, the PAL (prior authorization liaison) submits the PA (prior authorization) and receives all communications, such as decision notice letters, for the PDN.

PA grant and expiration dates for PDN services are authorized in 13-week segments for up to 52 weeks. Authorization will be listed in 13-week segments in the line items of the PA decision notice letter. Only the procedure code that the PAL is certified to provide will be indicated in the line items in the adjudication details of the decision notice letter; however, all authorized codes added to the PA by ForwardHealth are stated in the message section of the decision letter. The additional codes will not be listed on separate line items in the decision notice letter.

For example, the message section of the decision letter for the situation described in the sample will indicate that the PA is authorized for 99504 (TD), 99504 (TE), and T1026 (59):

- An NIP (nurse in independent practice) PDN PAL submits a PA request for nursing care in the home to a ventilator-dependent member that includes PDN services provided by a PCC provider; and
- ForwardHealth indicates 99504 below the heading "Service" and TD below the heading "Modifier" on the adjudication line items with the total units authorized for each 13-week segment.

Each PDN provider on the case is responsible for reading the decision notice letters before providing services.

Sample Prior Authorization Decision Notice Letter for Private Duty Nursing Services

Below is a sample prior authorization (PA) decision notice letter adjudication line items showing authorized PA for private duty nursing services submitted by a PA Liaison (PAL) .

Member Name: JANE MEMBER
Member Identification Number: 1234567890
Primary Diagnosis: 123.12
Secondary Diagnosis: 456.34

PA Number: 101210001
PA Status: APPROVED

Billing Practice Location Provider
Provider Name: ABC PROVIDER
Provider Address: 123 MAIN STREET
MADISON, WI 54321-1234
Provider Identification Number: 1112223334
Provider Taxonomy: 123A12345B
Provider ZIP Code: 54321-1234

MSG: 0123 – PA AUTHORIZED FOR PRIVATE DUTY NURSING SERVICES TO A VENTILATOR DEPENDENT MEMBER (99504 [TD] AND 99504 [TE]).
MSG: 4567 – PA AUTHORIZED FOR SERVICES AT A PEDIATRIC COMMUNITY CARE CENTER (T1026 [59]).
JOHN CONSULTANT, RN 05/01/2010

Line #	Line Status	Rendering Provider	Taxonomy	Service	Modifier	POS	Unit Auth	Dollar Auth	Grant Date	Expire Date	Group ID
01	APPROVED HOME VISIT MECH VENTILATOR	4445556667	321A54321B	99504	TD	12	1456.000	0.00	05/01/10	07/30/10	
02	APPROVED HOME VISIT MECH VENTILATOR	4445556667	321A54321B	99504	TD	12	1456.000	0.00	07/31/10	10/29/10	
03	APPROVED HOME VISIT MECH VENTILATOR	4445556667	321A54321B	99504	TD	12	1456.000	0.00	10/30/10	01/28/11	
04	APPROVED HOME VISIT MECH VENTILATOR	4445556667	321A54321B	99504	TD	12	1456.000	0.00	01/29/11	04/29/11	

Topic #5038

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, they will be able to correct the errors identified on the returned provider review letter directly on the ForwardHealth Portal. Once the provider has corrected the error(s), the provider can resubmit the PA (prior authorization) request or amendment request via the Portal to ForwardHealth for processing. When correcting errors, providers only need to address the items identified in the returned provider review letter or the amendment provider review letter. Providers are not required to resubmit PA information already submitted to ForwardHealth.

Topic #10357

Correcting Private Duty Nursing Returns on the Portal

For PDN (private duty nursing) services, the PAL (prior authorization liaison) submits the PA (prior authorization) and receives all communications, such as returned provider review letters, for the PDN.

The PAL can use the Portal to correct PA requests and amendments placed in "returned provider review" status even if the PA request or amendment was originally submitted on paper. Submitting the PA request and amendments via the ForwardHealth Portal may reduce the number of PA requests and amendments returned for clerical error.

Note: When changing or correcting requests and amendments, the PAL is required to revise or update documentation retained in his or her records. The PAL is to make available to other providers on the case the revised updated document for their review.

Topic #10097

Daylight Savings on the Decision Notice Letter

To accommodate daylight savings time for 24-hour cases, an hour will be subtracted in the spring for daylight savings time and an hour will be added in the fall for the return to standard daylight time. The changes to the number of authorized hours for the affected segments will be reflected in the PA (prior authorization) decision notice letter.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) decision notices and provider review letters via the secure area of the ForwardHealth Portal. PA decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Topic #9997

Private Duty Nursing Decision Notice Letters and Returned Provider Review Letters

For PDN (private duty nursing) services, the PAL (prior authorization liaison) submits the PA (prior authorization) and receives all communications, such as returned provider review letters, for the PDN.

Topic #425

Denied Requests

When a PA (prior authorization) request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about their right to a fair hearing. Only the **member, or authorized person acting on behalf of the member**, can appeal the denial.

Providers may call Provider Services for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the member and are encouraged to help the member understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a **new** PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)).

- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a noncovered service.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

    Division of Hearings and Appeals
    Department of Administration
    PO Box 7875
    Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #10358

Denied Requests for Private Duty Nursing

When a PA (prior authorization) request is denied for PDN (private duty nursing) services, the PAL (prior authorization liaison) and the member are notified. The PAL receives a PA decision notice, including the reason for PA denial. The PAL is required to submit a new PA request with a copy of the original denied PA request, additional supporting clinical documentation, and medical justification.

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on their right to a fair hearing. Only the **member, or authorized person acting on behalf of the member**, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the

member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a noncovered service.

Providers may call Provider Services for clarification of why a PA request was modified.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

    Division of Hearings and Appeals
    Department of Administration
    PO Box 7875
    Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #10359

Modified Requests for Private Duty Nursing

When a PA (prior authorization) request for PDN (private duty nursing) services is modified, both the PAL (prior authorization liaison) and the member are notified. The PAL will be sent a decision notice letter. A request to amend the modified PA request must be submitted by the PAL.

Topic #4737

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA (prior authorization) request when authorizing a grant date for the PA.

If a provider needs more than 30 days to submit the requested information, providers can request an extension by submitting a letter that explains why more time is needed to gather and submit the additional information requested. The letter seeking an

extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Topic #10360

Returned Provider Review Letter for Private Duty Nursing

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is responsible for responding to the returned provider review letter within 30 days. The PAL is responsible for making available to other PDN providers on the case the PA (prior authorization) request for their review.

Topic #427

Returned Requests

A PA (prior authorization) request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

If providers require more than 30 days submit corrections or required additional information, they can request an extension by submitting a letter that explains why more time is needed. The letter requesting an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the PA is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Topic #10377

Returned Requests for Private Duty Nursing

For PDN (private duty nursing) services, the PAL (prior authorization liaison) receives returned PA (prior authorization) requests and review letters and is required to make the corrections or supply the requested information, as appropriate. Because one PA for PDN services will be in effect for the member, multiple PA requests submitted from different providers for the same member will be returned to the submitting providers showing the PA request as a duplicate request.

Note: When the amendment request is changed or corrected, each PDN provider servicing the member is reminded to revise or update the documentation retained in their records. The PAL is to make available to other providers sharing the case the revised and updated documentation.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) requirement may be waived for services that normally require PA. Emergency services are defined in Wis. Admin. Code DHS 101.03(52) as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Topic #430

Urgent Situations

If a PA (prior authorization) request is required for an urgent situation, providers are required to submit the PA request in the ForwardHealth Portal.

ForwardHealth defines a PA request for a medically urgent situation as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could have the following impact:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Follow-Up to Decisions

Topic #4738

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the necessary information. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the **PA request** was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account:

- If the PA request was originally submitted via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.
- If the PA request was originally submitted via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal, as well as by mail.
- If the PA request was originally submitted via mail or fax and the provider does **not** have a Portal account, the decision notice letter or returned amendment provider review letter will be sent by mail to the address indicated in the provider's file as their PA address (or to the physical address if there is no PA address on file), **not** to the address the provider wrote on the PA request or amendment request.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) form to amend an approved or modified PA (prior authorization) request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request form. The Prior Authorization Amendment Request form may be submitted through the Portal, by mail or by fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper form.

Providers may request an amendment to an approved or modified PA request to:

- Temporarily modify a member's frequency of a service when there is a short-term change in their medical condition.
- Change the rendering provider information when the billing provider remains the same.
- Change the member's ForwardHealth identification number.
- Add or change a procedure code.

Note: ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Topic #2072

Prior Authorization Amendments for Home Health Services

Under certain circumstances, providers may amend an approved or modified PA. A request to amend a PA request may be submitted by fax or mail to ForwardHealth, or through the ForwardHealth Portal, and must be received by ForwardHealth

before the expiration date of the PA request to be amended.

Examples of these types of circumstances include, but are not limited to, the following:

- The member ID number changes.
- There is a short-term change in the member's medical condition and the frequency of a service needs to be modified temporarily, regardless of whether it is an increase or decrease in LOC (level of care) or hours. Physician orders that reflect the change are required.
- A provider reduces the number of hours of service because another provider begins to share the case. Requests for additional services by another provider may be denied if the number of services on the first PA is not reduced at the same time.
- A procedure code is added or changes.
- The rendering provider information changes when the billing provider remains the same.

Providers may also submit a reconsideration request in the form of an amendment when a PA has been modified. Request reconsideration by submitting a Prior Authorization Amendment Request with additional documentation that supports the original request. The amendment request should be received within 14 calendar days of the adjudication date on the original PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) or amendment. If the amendment request is approved, ForwardHealth will notify the provider of the effective date.

An amendment to an approved PA/RF must be requested any time the physician orders additional care, unless the additional services can be billed without PA and charged against one of the 30 outstanding PA threshold visits. This includes intermittent additional care due to fluctuations in the availability of the primary caregiver.

A new PA/RF must be submitted when changing requested nursing services from home health skilled nursing or home health aide to PDN (private duty nursing) or vice versa. Do **not** submit an amendment in these circumstances.

Note: If there is a significant, long-term change that requires a new POC (plan of care), then ForwardHealth recommends that providers enddate the current PA and submit a new request for PA.

The amendment request should include:

- A completed Prior Authorization Amendment Request describing the specific change requested and the reason for the request. Provide sufficient detail for ForwardHealth to determine the medical necessity of the requested services.
- A **copy** of the PA/RF to be amended (**not** a new PA/RF).
- A copy of the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)), the member's POC in another format that contains **all** of the components requested in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)) or the physician's orders. If current orders continue to be compatible with the new request, new orders are not necessary.
- Additional supporting materials or medical documentation explaining or justifying the requested changes.

PA amendment requests for PAs that did not contain the face-to-face visit documentation must be submitted prior to the expiration of the current PA and include documentation of a face-to-face visit that has occurred within 30 days of the start of services. PA amendment requests, if determined to be medically necessary, will be reviewed as follows:

- PA amendment requests without documentation of a face-to-face visit will be returned to the provider.
- PA amendment requests with documentation of a face-to-face visit that exceeds 30 days after the start of services will be granted on the date of the face-to-face visit.

Topic #10379

Prior Authorization Amendments for Private Duty Nursing

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is required to use the PA (prior authorization) Amendment Request to amend an approved or modified PA request. PA ammendments must be submitted by the same PAL who submitted the original PA request. The PAL is responsible for making amendment request documents available to the other PDN providers on the case. All providers on the case are responsible for making and maintaining their own copies of the decisions notice(s) generated from the amendment request.

Topic #432

Appeals

If a PA (prior authorization) request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA (Division of Hearings and Appeals). Decisions that may be appealed include the following:

- Denial or modification of a PA request
- Denial of a retroactive authorization for a service

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present their case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth and the member. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider to submit a claim for the service, the provider should submit the following to ForwardHealth after the service has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim
- A copy of the hearing decision
- A copy of the denied PA request

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the **new** PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service **before** the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision **upholds** the decision to deny or modify the PA request, the provider may collect payment from the member if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision **overturns** the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the **entire** amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse members.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #10397

Private Duty Nursing Appeals

For PDN (private duty nursing) services, if the DHA (Division of Hearings and Appeals) letter instructs to submit a claim for the service, each provider on the case should submit the following to ForwardHealth after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim
- A copy of the hearing decision
- A copy of the denied PA (prior authorization) request

For PDN services, if the DHA letter instructs to submit a new PA request, the PAL (prior authorization liaison) is required to submit the new PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) to end date most PA (prior authorization) requests. ForwardHealth does not accept requests to end date a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be end-dated by using STAT-PA (Specialized Transmission Approval Technology-Prior Authorization), in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to end date a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be end-dated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be end-dated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Topic #4739

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA (prior authorization) appears currently in the system, and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. If a provider requires more than 30 days to provide the corrections or additional required information, they can request an extension by submitting a letter that explains why more time is needed. The letter must be submitted via mail, fax, or electronic upload within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

After 30 days without a response, submission of the PA request or request for an extension, the amendment request status becomes inactive, and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will not be returned to the provider when corrections or additional information are needed; however, X-rays and dental models will be returned once the amendment request is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Topic #10418

Nurses in Independent Practice

For PDN (private duty nursing) services, if the amendment to a PA (prior authorization) request needs correction or additional information, a returned provider review letter will be sent to the PAL (prior authorization liaison) only. The PAL will be required to make the corrections or supply the additional information, as requested. ForwardHealth must receive the PAL's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the PAL is required to submit a new amendment request.

The PAL may correct an amendment request that has been in "returned provider review" status in the Portal, even if the PA amendment request was originally submitted on paper.

When the amendment request is changed or corrected, each PDN provider servicing the member is reminded to revise or update the documentation retained in his or her records.

Note: When changing or correcting the amendment request, the PAL is required to revise or update documentation retained in their records. The PAL is to make available to other providers sharing the case the revised and updated documentation for their review.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) requests, regardless of how the PA was initially submitted. If the provider knows the PA number, they can enter the number to retrieve the PA information. If the provider does not know the PA number, they can search for a PA by entering information in one or more of the following fields:

- Member identification number
- Requested start date
- Prior authorization status
- Amendment status

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Topic #10419

Nurses in Independent Practice

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is able to search for all previously submitted PA requests, regardless of how the PA was initially submitted.

Forms and Attachments

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of the following:

- The PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/2013))
- A service-specific PA attachment(s)
- Additional supporting clinical documentation (Typical PA requirements regarding attachments may not apply for some HealthCheck Other Services PA requests.)

Topic #13137

Enteral Nutrition Formula

The following must be submitted for PA requests for enteral nutrition formula:

- A PA/RF
- A PA/ENFA (Prior Authorization/Enteral Nutrition Formula Attachment, F-11054 (04/2020))
- A copy of the original prescription or order that is not greater than one year old
- Supporting clinical documentation that cannot be sufficiently indicated on the PA/ENFA

Billing providers or authorized representatives acting on behalf of billing providers are responsible for:

- Obtaining clinical documentation and information from prescribers necessary to submit PA requests. (Billing providers may have prescribers complete sections of the PA/ENFA if needed.)
- Signing the PA/RF and PA/ENFA.
- The truthfulness, accuracy, timeliness, and completeness of PA requests and submission of PA requests to ForwardHealth.

Enteral Nutrition Supplies

ForwardHealth covers enteral feeding supplies up to a maximum quantity per month without PA. Providers may refer to the DMS (disposable medical supply) Index for quantity limits.

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)), or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), a service-specific PA (prior authorization) attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment

about the case.

ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Topic #2086

Documentation Requirements - Home Health Skilled Nursing and Aides

Providers requesting PA (prior authorization) for home health skilled nursing and home health aide services are required to include the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and either the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) or the member's POC (plan of care) in another format that contains no less information than what is required in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)).

Providers are required to indicate the expected number of initial and subsequent visits per day, the number of days per week, and the number of weeks or months of service per service type on the PA/RF. The total number of visits requested per week on the PA/RF must match the number of weekly visits indicated on the POC. Services by another provider, whether another home health agency, NIP (nurses in independent practice), or volunteer, must be indicated on the POC.

Topic #2085

Documentation Requirements - Home Health Therapy

Providers requesting PA (prior authorization) for home health therapy services are required to include these items with the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)):

- The PA/HHTA (Prior Authorization/Home Health Therapy Attachment, F-11044 (07/2012)).
- The therapy evaluation.
- The therapy plan of care.
- The Individualized Family Service Plan (for children under three years of age enrolled in the Birth to 3 Program).

Providers must indicate the expected number of OT (occupational therapy) visits, PT (physical therapy) visits, and SLP (speech and language pathology) visits per day, the number of days per week, and the number of weeks or months of service per discipline on the PA/RF. The total number of visits requested must exactly match the number of visits indicated on the therapy evaluation and/or the plan of care.

Providers requesting PA both for home health therapy services and other home health services are only required to submit a single PA/RF for all services.

Providers may refer to a sample PA/HHTA.

Required Prior Authorization Request Information

A PA request for home health therapy services can only be approved if the request is complete, accurate, and includes this information:

- Reason for the referral.
- Diagnoses, including dates of onset.

- Character of the illness — acute, subacute, or chronic.
- Previous therapy — dates, frequency, amount, and types.
- Evaluations with respect to age, problems to be treated, and potential for achieving stated goals.
- Re-evaluations appropriate to progress.
- Rehabilitation potential — history including previous level of functioning, plan for discharge (for example, from therapy, from group home to apartment), plans for maintenance, member's motivation and cooperation with home health therapy plan, and potential for meeting realistic goals pertaining to functional status.
- Report of home health therapy treatment progress in specific objective and measurable terms.
- Documentation regarding carryover or follow through by the member and/or care giver toward the treatment goals.

Cotreatment

If two providers request cotreatment for one member, each provider is required to complete a separate PA request and submit them together. In addition to completion of PA requirements, this information must also be included:

- A specific request for cotreatment.
- Identification of the other provider and therapy discipline.
- Documentation verifying the following:
  - Individual treatment from a single PT, OT, or SLP provider does not provide maximum benefit to the member.
  - Two different therapy disciplines are required to *simultaneously* treat the member.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11044 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions (HCF 11044A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient
Recipient, Ima A.	**67**

3. Recipient Medicaid Identification Number

1234567890

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist

I.M. Performing, P.T.

5. Therapist's Medicaid Provider Number

87654321

6. Telephone Number — Therapist

(123) 456-7890

7. Name — Referring / Prescribing Physician

I.M. Referring

8. Referring / Prescribing Physician's Medicaid Provider Number

12345678

SECTION III — DOCUMENTATION

9. Provide a Brief History Pertinent to the Service(s) Requested

Recipient admitted to hospital 04/15/05 after CVA with residual left hemiparesis. Discharged home on 05/01/05 at insistence of wife. Nursing home placement unacceptable to family. Prior to CVA, recipient was independent in ADL and active around the house, in the community, and with his grandchildren. Recipient did have low endurance and fatigue due to COPD.

10. Provide a Description of the Recipient's Diagnosis and Problems as They Pertain to the Need for the Therapy Services requested (Include the date of onset)

Recipient hospitalization complicated by pneumonia. Recipient has history of long standing COPD and arteriosclerosis. In 2000 he had mitral valve replacement and double bypass surgery. In 2001 he had L radical neck resection. Recipient alert, feels frightened, exhibits poor safety awareness, and unsteady when ambulating.

Continued

SECTION III — DOCUMENTATION (Continued)

11. State Therapy History (Indicate type / date / location for all types of therapy)

Service Area	Location	Date	Problem Treated
Physical Therapy	**Hospital** **Home**	**04/18/05 to 4/30/05** **05/01/05 to present**	**Hemiplegia — therapeutic exercise, ROM, balance activities, ADL**
Occupational Therapy	**Hospital** **Home**	**04/18/05 to 4/30/05** **05/01/05 to present**	**Hemiplegia — motor skills**
Speech and Language Pathology	**Hospital** **Home**	**04/18/05 to 4/30/05** **05/01/05 to present**	**Dysphagia**

12. Indicate the Date of Initial Evaluation (Supply dates / tests used / results of additional evaluations)

ROM, MMT, ADL, Gait — 5/1/05. AAROM WNL all extremities, except as follows: R shoulder, Flex 0-130, ABD 0-120, IR 0-50; L shoulder flex 120, ABD 0-110, IR 0-30, BILAT Knees — 5 extension, transfers — moderate assist of one. Recipient has excessive trunk extension, ground weight bearing R LE, minimal weight bearing on LLE. Recipient requires min-moderate assist to complete all bed mobility. Moderate assist to ambulate for 100 feet times 3 with wheeled walker. Recipient becomes short of breath, has poor balance and excessive trunk extension.

13. Describe Progress in Measurable / Functional Terms Since Treatment Was Initiated or Last Authorized

Recipient remains as above. Recipient has active movements in all L LE joints. Movements independent, but with mild extensor tone in LLE and mild flexor tone in LUE. Supervision to minimal assist to complete pivot transfers. Recipient demonstrates proper technique and weight shifting from sit to stand: but continues to have excessive trunk extension from stand to sit. Recipient independent in bed mobility with tactile cueing. Good unsupported, unchallenged sitting balance. Recipient able to ambulate 200 feet with wheeled walker and supervision of one for occasional loss of balance backwards. Gait does exhibit decreased weight shift to L, minimal flexion in L LE decreased step length on R, decreased floor clearance with increased retraction L. hip.

14. Attach a Plan of Care Indicating Specific, Measurable Goals and Procedures to Meet Those Goals

See attached plan of care.

15. Describe Rehabilitation Potential

15. Describe Rehabilitation Potential

Excellent. Recipient has made excellent progress in the past month with 3X week therapy. He is well motivated and cooperates with therapy program. Anticipate recipient will be independent in ADL and gait if no complications occur and PT continues with home health aid carry through.

16. **SIGNATURE** — Requesting Provider	17. Date Signed
TM Performing P.T.	06/06/05

Topic #2084

Documentation Requirements - Medication Management

Providers requesting PA (prior authorization) for medication management services are required to include the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) and either the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) or the member's POC (plan of care) in another format that contains **all** of the components requested in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)).

Providers are required to indicate the expected number of visits per week and the number of weeks or months of service on the PA/RF. The total number of visits requested per week on the PA/RF must exactly match the number of weekly visits indicated on the POC. Services by another provider, whether another home health agency, NIP (nurses in independent practice), or volunteer, must be indicated on the POC.

Topic #2083

Documentation Requirements - Private Duty Nursing

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is responsible for submitting PA (prior authorization) request and supporting documentation.

PALs requesting PA for PDN services are required to include the following with the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)):

- The Private Duty Nursing Prior Authorization Acknowledgment (F-11041 (10/2008)).
- Either the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) **or** the member's POC (plan of care) in another format that contains **all** of the components requested in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)).

Private Duty Nursing Prior Authorization Acknowledgment

Agencies are required to submit a completed and signed Private Duty Nursing Prior Authorization Acknowledgment with all PA requests for PDN services. This form acknowledges that the member or the member's legal representative has read the POC and PA request.

Documenting Expected Hours on the PA/RF

Providers are required to indicate on the PA/RF the medically necessary number of PDN hours per day, the number of days per week, and the number of weeks. The total number of PDN hours requested on the PA/RF must be equal to or less than the number of hours ordered by the physician and indicated on the POC. Services by another provider, whether another home health agency, NIP (nurses in independent practice), pediatric community care, personal care provider, or volunteer, must also be indicated on the POC.

Topic #2082

Documentation Requirements for Home Health Services

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), providers are required to submit these attachments listed for each type of home care service.

Home Care Service Type	Prior Authorization Forms Required by Wisconsin Medicaid
Home Health Skilled Nursing	PA/RF. The plan of care that contains no less information than is required in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)).
Home Health Aide	PA/RF. The plan of care that contains no less information than is required in the PA/CPA Completion Instructions.
Private Duty Nursing (not ventilator-dependent and ventilator-dependent)	PA/RF. PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) **OR** the member's plan of care in another format that contains **all** of the components requested in the PA/CPA Completion Instructions. Private Duty Nursing Prior Authorization Acknowledgement (F-11041 (10/2008)).
Home Health Therapy	PA/RF. PA/HHTA (Prior Authorization/Home Health Therapy Attachment, F-11044 (07/2012)). Therapy plan of care. Therapy evaluation. Individualized Family Service Plan (for children under three years of age).

Topic #447

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA (prior authorization) forms and attachments. In addition, providers may download and complete most PA attachments from the ForwardHealth Portal.

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd

Madison WI 53784

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Portal. Many forms are available in fillable PDF and fillable Microsoft Word formats.

Web PA Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Topic #448

Prior Authorization Request Form

The PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process the claim for prior authorized services.

Topic #2081

Prior Authorization Request Form Completion Instructions for Home Health Services

The following sample PA/RFs (Prior Authorization Request Form, F-11018 (04/2026)) for home health services are available:

- Sample PA/RF for home health skilled nursing and home health aide services
- Sample PA/RF for home health skilled nursing requesting PRN (pro re nata) visits
- Sample PA/RF for home health therapy services

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA (prior authorization) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA for certain procedures/services. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents submitted to ForwardHealth. Providers may submit PA requests, along with the POC (plan of care) containing no less information than is required for the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) for home health skilled nursing and home health aides services or the PA/HHTA (Prior Authorization/Home Health Therapy Attachment, F-11044 (07/2012)) for home health therapy services via their secure ForwardHealth Portal account, by fax, or by mail.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck Other Services and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck Other Services if the services requested on the PA/RF are for HealthCheck Other Services. Enter an "X" in the box next to WCDP (Wisconsin Chronic Disease Program) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter process type 120 for home health services. The process type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if a process type is not indicated.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the NPI (National Provider Identifier) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

Element 6a — Name — Prescribing/Referring/Ordering Provider
Enter the prescribing/referring/ordering provider's name.

Element 6b — National Provider Identifier — Prescribing/Referring/Ordering Provider
Enter the prescribing/referring/ordering provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct number.

Element 8 —Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code.

Element 10 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specifity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 17 — Rendering Provider Number (not required)

Element 18 — Rendering Provider Taxonomy Code (not required)

Element 19 — Service Code
Enter the appropriate CPT (Current Procedural Terminology) code or HCPCS (Healthcare Common Procedure Coding System) procedure code for each service/procedure requested.

Element 20 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 21 — POS
Enter POS (place of service) code "12." The member's home is the only allowable POS.

Element 22 — Description of Service
Enter a written description corresponding to the appropriate procedure code for service/procedure requested.

When requesting PDN (private duty nursing) services, indicate the number of hours per day, multiplied by the number of days per week, multiplied by the total number of weeks being requested.

If sharing a case with another provider, enter "shared case" and include a statement that the total number of hours of all providers will not exceed the combined total number of hours ordered on the physician's POC. When requesting two procedure codes to be used interchangeably, include a statement that the total number of hours will not exceed the combined total number of hours ordered on the physician's POC. When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits to do (number of) continuous hours of care."

Element 23 — QR
Enter the appropriate quantity (for example, number of services, days' supply) requested for the procedure code listed.

Element 24 — Charge
Enter the provider's usual and customary charge for each service/procedure. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by DHS (Department of Health Services).

Element 25 — Total Charges
Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting/performing this service/procedure must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Sample PA/RF for Home Health Skilled Nursing and Home Health Aide Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	120	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. ORDERING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
E11.9 — Type 2 diabetes mellitus without complications	MM/DD/CCYY	

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
I10 —Essential (primary) hypertension	

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		99600					12	HHN — initial visit, 1 visit/day x 3 days/wk x 29 wks	87	XX.XX
		T1021					12	HHA — initial visit, 1 visit/day x 7 days/wk x 29 wks	203	XX.XX
		99600	TS				12	HHN — follow-up visit, 1 visit/day x 3 days/wk x 29 wks	87	XX.XX
		T1021	TS				12	HHA — follow-up visit, 1 visit/day x 7 days/wk x 29 wks	203	XX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Sample PA/RF for Home Health Skilled Nursing Requesting Pro Re Nata Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
☐ HealthCheck "Other Services" ☐ Wisconsin Chronic Disease Program (WCDP)	120	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. ORDERING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	☐ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
E11.9 — Type 2 diabetes mellitus without complications	MM/DD/CCYY	

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
I10 — Essential (primary) hypertension	

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		99600					12	HHN — initial visit, 1 visit/day x 3 days/wk x 29 wks	81	XXX.XX
								3 PRN visits/month x 1 month		

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Sample PA/RF for Home Health Therapy Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
☐ HealthCheck "Other Services" ☐ Wisconsin Chronic Disease Program (WCDP)	120	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. REFERRING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	☐ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
I25.10 — Athscl heart disease of native coronary artery w/o ang pctrs		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
E11.9 — Type 2 diabetes mellitus without complications	MM/DD/CCYY

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		97799					12	HH — physical therapy 1 visit/day x 3 days/wk x 26 wks	78 visits	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Topic #1108

Prior Authorization Request Form Completion Instructions for Private Duty Nursing

The following are sample PA/RFs (Prior Authorization Request Forms, F-11018 (05/2013)) for PDN (private duty nursing) services:

- Sample PA/RF for an NIP (Nurse in Independent Practice) requesting PDN for a ventilator-dependent member
- Sample PA/RF for HHA (home health aide) requesting PDN for a member attending a PCC (pediatric community care) center

An NIP acting as the PDN PAL (prior authorization liaison) must indicate on the PA (prior authorization) request the procedure code for the PDN services that the RN (registered nurse) is to provide (S9123 or 99504 with modifier TD). When the PA request is adjudicated, ForwardHealth will add the corresponding procedure code (S9124 or 99504 with modifier TE) for PDN services that LPNs (licensed practical nurses) might provide.

For PA requests submitted by an NIP via the Portal for PDN services that include PDN services provided by PCC providers, the procedure code T1026 and modifier 59 must be included in the "Additional Service Code Description" field.

For paper PA requests submitted by an NIP by fax or by mail for PDN services that include PDN services provided by PCC providers, the procedure code T1026 and modifier 59 must be included in Element 21 (Description of Service). Refer to the sample PA/RF for PDN services requested by a PAL who is an NIP.

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. The use of the PA/RF is mandatory to receive PA for certain items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should retain copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the POC (plan of care) containing no less information than is required for the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) and the Private Duty Nursing Prior Authorization Acknowledgment (F-11041 (10/2008)), via the ForwardHealth Portal, by fax to ForwardHealth at 608-221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck Other Services and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck Other Services if the services requested on the PA/RF are for HealthCheck Other Services. Enter an "X" in the box next to WCDP (Wisconsin Chronic Disease Program) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter process type "120" — PDN. The process type is used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no process type is indicated.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the PAL.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the PDN PAL. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the PDN PAL's number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the NPI (National Provider Identifier) of the PDN PAL. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the PDN PAL's NPI in Element 5a.

Element 6a — Name — Prescribing/Referring/Ordering Provider
Enter the prescribing/referring/ordering provider's name.

Element 6b — National Provider Identifier — Prescribing/Referring/Ordering Provider
Enter the prescribing/referring/ordering provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct number.

Element 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format (for example, September 8, 1966, would be 09/08/1966).

Element 9 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code.

Element 10 — Name — Member
Enter the member's last name, followed by their first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (not required)

Element 14 — First Date of Treatment — SOI [not required]

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 17 — Rendering Provider Number (not required)

Element 18 — Rendering Provider Taxonomy (not required)

Element 19 — Service Code
Enter the appropriate CPT (Current Procedural Terminology) code or HCPCS (Healthcare Common Procedure Coding System) code for each service the PDN PAL will be providing.

When the PDN PAL is a NIP or a HHA (home health angency), only the procedure code for PDN services that are provided by the RN should be placed in this element.

When the PDN PAL is a PCC provider, only the procedure code for the PDN services that are provided by the PCC provider should be placed in this element.

Note: If the provider needs additional spaces for Elements 18–23 for the PA request, the provider may complete additional PA/RF(s). The PA/RFs should be identified, for example, as "page 1 of 2" and "page 2 of 2."

Element 20 — Modifiers
Enter the appropriate modifier for the procedure code listed, as applicable

Element 21 — POS
Enter the appropriate POS (place of service) code designating where the requested service will be performed. Includes, but is not limited to, the following:

- 03 (School)
- 12 (Home)
- 99 (Other Place of Service)

Element 22 — Description of Service
For PDN services, the description of service must contain the following information:

- Enter a written description corresponding to the appropriate CPT or HCPCS code for the PDN services requested.
- Enter the number of hours per day, number of days per week, and the number of weeks being requested. (The total number of hours requested should not exceed the number of hours ordered by the physician on the POC).

Other information may be needed in the description of service for the following situations:

- When the PDN PAL is an NIP or an HHA and the member also attends a PCC program, the PDN PAL must enter the procedure code T1026 and modifier 59 for the PDN services that are provided by the PCC provider.
- When the PDN PAL is a PCC provider and the member also requests PDN services for times when they are not attending the PCC program, then the PCC PDN PAL must enter the procedure code and modifier (if needed) for the PDN services that are to be provided by an RN into this element (99504-TD for PDN for ventilator dependent members or S9123 for non-ventilator dependent members).

Element 23 — QR
Enter the appropriate quantity (for example, number of services) requested for the procedure code listed.

Element 24 — Charge
Enter the usual and customary charge for each service requested.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the provider Terms of Reimbursement issued by the Wisconsin DHS (Department of Health Services).

Element 25 — Total Charges
Enter the anticipated total charges for this request. If the provider completed a multiple-page PA/RF, indicate the total charges for the entire PA request on Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 should refer to the last page (for example, "SEE PAGE TWO").

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Sample PA/RF for a Nurse in Independent Practice Requesting PDN for a Ventilator-Dependent Member

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	120	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220	123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. ORDERING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
Z99.11 — Dependence on respirator [ventilator] status		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
G80.9 — Cerebral palsy, unspecified	MM/DD/CCYY

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		99504	TD				12	PDN for ventilator dependent member 16 hours per day, 7 days per week X 52 w	5824	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Sample PA/RF for Home Health Aide Requesting PDN for a Member Attending a Pediatric Community Care Center

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	120	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220
	5b. Billing Provider Taxonomy Code 123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. ORDERING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
P27.0 — Wilson-Mikity syndrome		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
G80.9 — Cerebral palsy, unspecified	MM/DD/CCYY

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		S9123					12	PDN for member 10 hours per day, 5 days per week X 52 weeks	2600	XXX.XX
								Case shared with PCC T1026 (59)		

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Topic #1110

Private Duty Nursing Prior Authorization Acknowledgment

Wisconsin Medicaid requires the PDN (private duty nurse) PAL (prior authorization liaison) to submit a completed and signed Private Duty Nursing Prior Authorization Acknowledgment (F-11041 (10/2008)) with all PA (prior authorization) requests. This form acknowledges that the member or the member's legal representative has read the POC (plan of care) and PA request.

Topic #1111

Required Documentation for Private Duty Nursing Prior Authorization Requests

The PAL (prior authorization liaison) is required to submit the following completed forms for PDN (private duty nursing) PA (prior authorization) requests:

- PA/RF (Prior Authorization Request Form, F-11018 (04/2026)).
- Private Duty Nursing Prior Authorization Acknowledgment (F-11041 (10/2008)).
- The POC (plan of care) containing no less information than is required for the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)).

The PAL is required to make the PA request available for other PDN providers on the case to review.

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a provider's prescription, clinical reports, and other materials related to the member's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the member's name and member identification number. Securely packaged X-rays and dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Topic #14038

When a Home Health Agency is the Prior Authorization Liaison

PA (prior authorization) requests for PDN (private duty nursing) services submitted by a home health agency should not include

any procedure code for a service that is not PDN. Requests for PDN services combined with requests for other services will be returned to the provider.

Home health agencies acting as the PDN PAL (prior authorization liaison) must indicate on the PA request the procedure code for the PDN service that an RN (registered nurse) is to provide (S9123 or 99504 with modifier TD). When the PA request is adjudicated, ForwardHealth will add the applicable corresponding procedure code for the PDN services an LPN (licensed practical nurse) might provide (S9124 or 99504 with modifier TE). If the PA request is authorized, the applicable procedure codes for PDN services will be stated in the PA decision notice letter.

For PA requests submitted by a home health agency via the Portal for PDN services that include PCC (pediatric community care) services, the procedure code T1026 with modifier 59 must be included in the "Additional Service Code Description" field.

For paper PA requests submitted by home health agency by fax or mail for PDN services that include PDN services provided by PCC providers, the procedure code T1026 and modifier 59 must be included in Element 21 (Description of Service).

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned—Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending—Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending—Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending—State Review	The PA request is being reviewed by the State.
Suspend—Provider Sending Information	The PA request was submitted via the ForwardHealth Portal, and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.
Inactive—Void	The PA request is either: - Submitted but not required. - A provider requests to rescind the PA request. - Submitted in error.

Topic #434

Communication With Members

ForwardHealth recommends that providers inform members that PA (prior authorization) is required for certain specified services **before** delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the **entire** PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received

by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Topic #10457

Private Duty Nursing

For PDN (private duty nursing) services, the member is advised to contact the PAL (prior authorization liaison) about the status of a PA request.

Topic #435

Definition

PA (Prior authorization) is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA **before** providing services that require PA. When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

Topic #2080

PA requests may be submitted no earlier than 62 days prior to the requested effective date.

Topic #5098

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA (prior authorization) will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Providers may designate a separate address for PA correspondence using the demographic maintenance tool.

Topic #10477

Private Duty Nursing

For PDN (private duty nursing) services, correspondence related to PA (prior authorization) will be sent to the PAL (prior authorization liaison)'s practice location address on file with ForwardHealth unless the PAL designates a separate address for receipt of PA correspondence.

Topic #2079

Disposable Medical Supplies

Refer to the DMS (disposable medical supplies) Index and the DMS area of the Online Handbook for information on requesting PA (prior authorization) for DMS.

Topic #2078

Durable Medical Equipment

Refer to the DME (durable medical equipment) Index and the DME area of the Online Handbook for information on requesting PA (prior authorization) for DME.

Topic #2075

Members With Changing Nursing Needs

If the member's medical condition worsens so that eight or more hours of direct, skilled nursing services are required in a calendar day, a maximum of 30 calendar days of skilled nursing care may continue to be reimbursed as home health services, beginning on the day eight hours or more of skilled nursing services became necessary. To continue medically necessary services after 30 days, PA (prior authorization) for PDN (private duty nursing) is required.

Members Who No Longer Require Private Duty Nursing

If the condition of a member receiving PDN services improves to the point that less than eight hours of direct, skilled nursing care are required in a calendar day, the member is no longer eligible for PDN. An alternate level of care such as intermittent skilled nursing visits, home health aide visits, or personal care services may be more appropriate.

Topic #2076

Other Members of a Member's Household

ForwardHealth encourages other members of a member's household to participate in providing care to the member. However, this participation is not a condition of coverage.

With the permission of the member or the member's legal representative, the provider should ask members of the household about the extent they are able and willing to provide medically necessary covered services for the member. If household members are not willing or able to provide care, the nurse should document the reasons why in the member's medical record.

When medically necessary covered services that are normally furnished by the provider are instead provided by willing and able household members, these services cannot be billed to ForwardHealth.

Topic #2077

Personal Care Services

If the member is receiving both personal care services and home health services from the home health agency, the agency is required to request separate PA (prior authorization) requests for home health services and personal care services. PA requests submitted with home health services and personal care services listed on the same request will be returned to the provider to submit the services in two separate requests.

Services added during the term of the current approved authorization must be submitted using a PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) for the requested service. Providers should refer to the Personal Care service area of the Online Handbook for further information about personal care services.

Topic #4383

Prior Authorization Numbers

Upon receipt of the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), ForwardHealth will assign a PA (prior authorization) number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (for example, the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following table provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media—One digit indicates media type.	Digits are identified as follows: 1 = paper; 2 = fax; 3 = STAT-PA (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services Review—Request for Review and Response) transaction; 9 = eviCore healthcare
Year—Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date—Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number—Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Topic #1116

Private Duty Nursing Services Requiring Prior Authorization

All PDN (private duty nursing) services require PA (prior authorization) as stated in Wis. Admin. Code § DHS 107.12(2)(a). Wisconsin Medicaid does not reimburse for PDN if the services are provided without an approved PA.

For initial or renewal requests, the PAL (prior authorization liaison) is encouraged to submit PA requests at least 30 days before they plan to begin providing services. PA requests may be submitted no earlier than 62 days prior to the requested effective date.

Topic #436

Reasons for Prior Authorization

Only about 4% of all services covered by Wisconsin Medicaid require PA (prior authorization). PA requirements vary for different types of services. Refer to ForwardHealth publications and Wis. Admin. Code ch. DHS 107 for information regarding services that require PA. According to Wis. Admin. Code § DHS 107.02(3)(b), PA is designed to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and members.

PA requests are processed based on criteria established by Wisconsin DHS (Department of Health Services).

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to out-of-state providers when nonemergency services are necessary to help a member attain or regain their health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet ForwardHealth's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (for example, anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state provider, the referring provider should instruct the out-of-state provider to go to the Provider Enrollment Information home page on the ForwardHealth Portal to complete a Medicaid Out-of-State Provider Enrollment Application.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state nonborder-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Topic #10478

Private Duty Nursing

There are no emergency services for PDN (private duty nursing) services. Initial PA requests may be backdated up to 14 days.

Topic #438

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of these program requirements are not met:

- The service authorized on the approved PA (prior authorization) request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets other program requirements.

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

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

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Topic #1115

Responsibility for Private Duty Nursing Prior Authorization

The PAL (prior authorization liaison) is responsible for submitting a complete, accurate, and timely PA (prior authorization) request including all attachments. Failure to fully complete the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) or other required attachments may delay processing.

By requesting PA for services, a provider attests through the documentation to Wisconsin Medicaid that, to the best of the PAL's knowledge, care is medically necessary.

Requests for PA for PDN (private duty nursing) services must be accompanied by the following forms and completed according to the completion instructions:

- PA/RF
- The POC (plan of care) containing no less information than is required for the PA/CPA (Prior Authorization/Care Plan Attachment Form, F-11096 (08/2015))
- Private Duty Nursing Prior Authorization Acknowledgement (F-11041 (10/2008))

All providers sharing the case are required to obtain a copy of the POC for the effective certification period and countersign the

POC to document that the provider has reviewed the POC and will execute it as written. The provider's dated countersignature must be on the POC before providing PDN services.

By countersigning the POC, the provider confirms that all information on the plan of care is complete and accurate, and that the provider is familiar with all of the information entered on the form.

Topic #2074

Services Requiring Prior Authorization

ForwardHealth requires PA (prior authorization) for the following services provided by home health agencies:

- All home health skilled nursing, medication management, home health aide, and home health therapy visits by all providers after the first 30 visits in a calendar year.
- Visits made by **all** providers from the home health agency accumulate toward the 30-visit threshold. After the first 30 visits, if one provider in a shared case requires PA, all providers on that case are required to have PA.
- All PDN (private duty nursing) services as stated in Wis. Admin. Code § DHS 107.12(2)(a).
- All home health and PCW (personal care worker) services that are provided in conjunction with PDN services.
- All home health services provided by NIP (nurses in independent practice).

Providers are required to include the initial prescription and documentation of the face-to-face visit with the prescriber when submitting PA.

Initial PA requests received without the face-to-face visit documentation will only be granted for up to 60 days to allow for the face-to-face visit to occur and the documentation to be submitted with an amendment to the PA. A valid prescription is required with the initial PA request.

Wisconsin Medicaid does not reimburse these services if they are provided:

- Without an approved PA.
- Before the grant date on the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)).
- After the expiration date on the PA/RF.

PA does not guarantee reimbursement. Provider eligibility, member enrollment, and medical status on the DOS (date of service), as well as all other ForwardHealth requirements, must be met before the claim is paid.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101–109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43–49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system
- Calling Provider Services

Providers should have the 10-digit PA number available when making inquiries.

Topic #10479

Private Duty Nursing Status Inquiries

For PDN (private duty nursing) services, providers who are not the PAL (prior authorization liaison) may contact Provider Services. For Providers Services to share information regarding the PDN PA, providers are required to supply the following information:

- The name and provider number of the enrolled PDN provider requesting the information
- The member's name, date of birth, and member ID
- The PA number and the name of the PAL

Topic #2073

Two Caregivers Providing Care for a Member at the Same Time

When it is medically necessary and PA (prior authorization) has been obtained, Wisconsin Medicaid may reimburse for a PCW (personal care worker) to assist an RN (registered nurse), LPN (licensed practical nurse), home health aide, or another PCW. If two providers are caring for a member simultaneously, one provider must be a PCW. The situations in which a PCW may assist are:

- Periodic changing of the entire tracheostomy tube
- Periodic transfer or repositioning of a member when a two-person transfer is required to assure safety because all other transfer devices have failed

The provider is required to document on the POC (plan of care) the reason that two caregivers are required.

Grant and Expiration Dates

Topic #439

Backdating

An initial PA (prior authorization) request start date may be backdated up to 14 calendar days prior to ForwardHealth's initial receipt of the PA request.

Extraordinary Circumstances Criteria

ForwardHealth may approve a request for backdating if all of these conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request includes the reason why the request was submitted more than 14 days after the requested start date.

Examples of extraordinary circumstances include:

- A court order or hearing decision requiring Wisconsin Medicaid coverage is attached to the PA request.
- The member is retroactively enrolled. (Indicate in Element 21 of the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) that the service was provided during a period of member retroactive enrollment. In Element 15, indicate the actual date the service was provided.)
- The provider is on a correction plan.

ForwardHealth may modify or deny a PA request if the PA request is received more than 14 calendar days after the DOS (date of service) and does not meet the extraordinary circumstances criteria. If the PA request is modified or denied and a service has already been rendered, the provider cannot require payment from the member.

Topic #2071

Returned Requests

An initial PA request returned for additional information may be backdated 14 calendar days from the date it was initially received by ForwardHealth if the additional corrected information is returned with the original PA/RF.

Amendment Requests

PA amendment requests may be backdated 14 calendar days from the date of receipt by ForwardHealth if the request is for urgent situations in which medical necessity could not have been predicted.

Amendment requests may also be backdated to the grant date on the original PA request for the following two reasons:

- The amendment request is directly related to a modification of the original request **and** ForwardHealth receives the amendment request within 14 days of the adjudication date on the original PA/RF.
- The amendment request results from an error on the original adjudication.

Denied Requests

Once a PA request has been denied, that PA number can no longer be used. A new PA number must be used with a new request. A new request following a denial may be backdated to the original date the denied request was received by ForwardHealth when all the following criteria are met:

- The earlier grant date is requested.
- The denied PA request is referred to in writing.
- The new PA request has information to justify approval.
- The request for reconsideration submitted with additional supporting documentation is received within 14 calendar days of the adjudication date on the original denied PA request.

Subsequent Requests Will Not Be Backdated

ForwardHealth will not backdate subsequent PA requests for continuation of ongoing services. To prevent a lapse in coverage, all subsequent PA requests must be received by ForwardHealth prior to the expiration date of the previous PA.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Topic #8597

PA for home health services is never granted for more than a 12-month period.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Topic #442

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA (prior authorization) requests (subsequent PA requests for ongoing services) must be received by ForwardHealth **prior to the expiration date** of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Topic #10480

Private Duty Nursing Renewal Requests

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is responsible for timely submission of PA request renewals.

Topic #20997

Face-to-Face Prior Authorization Renewal Requests

PA renewal requests are reviewed as follows:

- Renewals for services prior authorized before July 1, 2018, do not need face-to-face visit documentation and will be processed.
- Renewals for services initially prior authorized after July 1, 2018, received with face-to-face visit documentation or amended to add face-to-face documentation, will be processed.
- Renewals for services initially prior authorized after July 1, 2018, not amended to include face-to-face visit documentation, will be returned to the provider for face-to face documentation.

Home Health Skilled Nursing, Medication Management, Home Health Aide

Topic #2070

30-Visit Threshold

A member may receive a total of 30 visits, including home health skilled nursing services, medication management services, home health aide services, and home health therapy services, per calendar year before PA (prior authorization) is required. PA is required when the total of any combination of these services per member exceeds 30 visits, regardless of the provider or service.

For example, if a member received 10 home health aide initial visits, five home health aide subsequent visits, five home health skilled nursing initial visits and 10 physical therapy visits, for a total of 30 visits, PA is required before any further services will be reimbursed by Wisconsin Medicaid during the same calendar year.

If the member has received home health services from another provider during the calendar year, those visits are also counted toward the 30-visit threshold.

Although providers are permitted to provide 30 visits without PA in a new calendar year, providers are encouraged to request PA immediately upon completion of the POC (plan of care) so that reimbursement is not jeopardized.

Topic #3664

Continuous Visits

Providers may request PA (prior authorization) to enable them to bill for multiple home health aide visits. The provider is required to indicate the following on the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)): "Authorization requested to bill for (number of) subsequent HH (Home Health) aide visits due to (number of) continuous hours of care."

Documentation submitted must support the medical necessity of the continuous visits.

In determining the number of continuous home health aide visits PA will be granted for, consideration will be given to the member's needs and special circumstances.

Topic #2069

Medication Management

Skilled nursing visits for medication management count toward the 30-visit threshold for PA (prior authorization).

Topic #2068

Ongoing Assessments

Ongoing assessments do not require PA (prior authorization) and do not count toward the 30-visit threshold.

Topic #2067

Pro Re Nata Visits

Providers may request PRN (pro re nata), or "as needed," visits only when service is likely to vary due to changes in the member's need for services. If the use of PRN visits is anticipated, the specific number of PRN visits must be included in the POC (plan of care) and requested by procedure code per week or month of service on the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) as demonstrated in this example. PRN visits must be added to the regularly scheduled number of visits requested for a particular procedure code. The reason for the PRN visits must be explained based on member-centered parameters.

Topic #2066

Shared Cases

For each calendar day, there can only be one initial visit for any given procedure code, regardless of the number of providers administering services to the member on that day. Providers with shared cases should coordinate with each other to determine which agency will provide the initial visit. This information must be indicated on the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)). Additional visits for the same procedure code on the same calendar day are classified as subsequent visits.

Providers should verify that requests for PA specify the appropriate number and type of visits to assure consistent member care and proper reimbursement. For this reason, coordination between providers of shared cases is strongly encouraged.

Member Eligibility Changes

Topic #443

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and end dates, Wisconsin Medicaid will **not** reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Topic #444

Retroactive Disenrollment From State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS (date of service). The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the

service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.

- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Topic #10481

Private Duty Nursing Retroactive Requests

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is responsible for submitting a retroactive PA request.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Topic #10482

Private Duty Nursing Retroactive Approvals

For PDN (private duty nursing) services, if a service(s) that requires PA was performed during a member's retroactive enrollment period, the PAL (prior authorization liaison) is required to submit a PA request and receive approval from ForwardHealth before the PDN provider submits any claim.

Plan of Care

Topic #2065

A Comprehensive Overview

Home health services must be provided according to the member's written, signed, and dated plan of care as defined in Wis. Admin. Code § DHS 105.16(1).

Topic #2064

Certification Period

Each certification period may last no longer than 62 days. The 62-day period corresponds with the certification period dates in Element 4 of the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) and includes both the "From" date and the "To" date. The POC (plan of care) expires at the end of the 62-day certification period. (Medicare-enrolled agencies should use the time frame of up to, but not more than, **60 days** later.)

All components of the POC are required to be reviewed by a physician at least every 62 days as stated in Wis. Admin. Code § DHS 105.16(1). If multiple physicians order services, orders are combined on one POC and reviewed, signed, and dated by the primary physician at least every 62 days. The home health agency has the responsibility to sign and confirm the date that the information on the POC was reviewed with the physician, to verify that the POC is complete, and to keep a current and complete POC on file.

Once the physician reviews, signs, and dates the POC, it serves as the physician's orders for the length of the certification period.

The physician must review, sign, and date all subsequent POC **prior** to the beginning certification date on the POC. Otherwise, the agency is providing services without orders, and such services will not be reimbursed by Wisconsin Medicaid.

Topic #2063

Changes to the Plan of Care

When the member's medical needs change, the provider is required to notify the physician so that the physician may order a change to the POC (plan of care) to reflect the member's current medical needs.

It is illegal to add or change orders on a POC after it has been signed by a physician. To add or change orders, providers must have on file a signed and dated copy of the new physician orders to the POC. These changes must be incorporated into the next POC, prior to it being signed by the physician.

ForwardHealth will **not** accept correction fluid or correction tape on a POC. When correcting errors on a POC before it is signed, a nurse should cross out the error with a single line and place his or her initials and date next to the correction. ForwardHealth will return a POC with other methods of correction to the provider.

Topic #1122

Completing the Plan of Care

As required in Element 24 of the PA/CPA Completion Instructions (F-11096A (09/2015)), the RN (registered nurse) **completing** the POC (plan of care) is required to sign the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)). To **complete** the POC, the RN is required to do all of the following:

- Develop the nursing POC to include no less information than what is required by the PA/CPA completion instructions.
- Review the information provided in the POC to assure that all required components are included.
- Review the information provided in the POC to assure that it is correct.

Under Wis. Admin. Code § N 6.03, an RN is responsible for the POC. Under Wis. Admin. Code § N 6.04, an LPN (licensed practical nurse) may **assist** with the development and revision of the POC.

Someone other than the RN may key the required components into the document, but the RN signing the POC takes full responsibility for the contents of the POC.

Topic #2062

Developing the Plan of Care

Development of the POC (plan of care) should be based on the orders of a physician, a visit to the member's residence by either an RN (registered nurse) or therapist as appropriate, and in consultation with the physician, the member, or, as appropriate, the member's legal representative, the member's family, and other members of the household.

When developing the POC, the provider should also assess the member's social and physical environment, including the following:

- Family involvement.
- Living conditions.
- The member's level of functioning.
- Any pertinent cultural factors.

LPNs (licensed practical nurses) may not develop the POC.

Topic #2061

Documentation Methods

When completing and submitting the POC (plan of care), home health providers may use either the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) or another format that contains **all** of the components requested in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)).

When completed according to the completion instructions, the PA/CPA contains the information required to adjudicate a provider's PA (prior authorization) request for home care services.

Each provider should respond to the PA/CPA Completion Instructions consistent with his or her provider type and the services being provided under the POC.

Complete and accurate information is required to adjudicate PA requests submitted for home care services. Incomplete PA requests will be returned to the provider.

Topic #1124

Element 26 of the Prior Authorization/Care Plan Attachment

If the nurse signing and dating Elements 24 and 25 of the PA/CPA (Prior Authorization/Care Plan Attachment Form, F-11096 (08/2015)) receives verbal orders from the attending physician to start care for the initial certification period, the nurse should enter the date the verbal orders were received in Element 26. If the nurse did not receive verbal orders, Element 26 should be left blank.

Topic #1133

Elements 24 and 25 of the Prior Authorization/Care Plan Attachment

Regardless of whether the physician's order is for the start of care with the initial certification period or for continuing care with a recertification period, the RN (registered nurse) completing the POC (plan of care) is required to sign and date the POC as instructed for Elements 24 and 25 of the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)). The RN completing the POC must sign and date the POC on or before the certification period "From" date indicated on the POC. By signing and dating the POC, the RN attests to the following:

- The information contained in the POC is complete and accurate.
- They are familiar with all of the information in the POC.
- When providing services, they are responsible for ensuring that the POC is carried out as specified.

Elements 24 and 25 must be completed on or before the certification period "From" date indicated in Element 4 of the PA/CPA.

Topic #1136

Indicating Flexible Use of Hours on the Plan of Care

When the flexible use of hours is requested for PDN (private duty nursing), providers are required to specify the date(s) that the flexibility period(s) will begin. Enter the flexibility begin dates on the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) in Element 15 — Orders for Services and Treatments. The begin date(s) must be a date (or dates) covered under the POC (plan of care).

Topic #2060

Medical Necessity and the Plan of Care

The member's health status and medical need, as reflected in the POC (plan of care), provide the basis for determinations as to whether services provided are reasonable and medically necessary.

Each provider is responsible, along with the physician, for the contents of the POC relating to the medical necessity of care, accuracy of all information submitted, and relevance of the POC to the member's current medical condition. Providers are required to do the following:

- Promptly notify the member's physician of any change in the member's condition that suggests a need to modify the POC.
- Implement any changes that were made to the POC.

Providers are required to include a complete, detailed, and accurate description of the member's medical condition and needs in the POC. The POC should be developed and reviewed concurrently and in support of other health care providers providing services to the member in the home.

Topic #2059

Physician Signature Extension for Member Plans of Care

ForwardHealth recognizes that Medicare-enrolled home health agencies can encounter difficulties obtaining a physician's signature for POC (plan of care) recertifications within the time designated by Wisconsin Administrative Code. In response, Wisconsin DHS (Department of Health Services) has established a process and created a form titled Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement (F-01017 (08/2019)) to expedite requests for a 20 working day extension to obtain the physician's signature. (Working days refer to Monday through Friday.) The variance is limited to verbal orders for POC recertification periods. The variance will increase the time providers have to obtain the physician's signature on a member's POC.

When requesting a variance to the administrative code pertaining to requirements for having the physician review the member's POC and obtaining the physician's dated signature on the member's written POC prior to recertification periods, DHS recommends home health agencies use the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement form.

Submitting a Variance Request

Only Wisconsin Medicaid-enrolled home health agencies that are Medicare-enrolled may submit the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement form.

Any branch of a Medicare-enrolled home health agency that is assigned its own unique provider number must submit a **separate** request form to also receive the variance.

Providers should not submit a request for each member. Only one form per provider number should be submitted.

Obtaining the Physician's Signature

Under the variance, agencies will be required to obtain the physician's signature on the member's written POC before submitting claims for services to ForwardHealth. The physician's signature must be obtained no later than 20 working days following the "From" date listed on the POC for the recertification period. This is also the same date listed as the "From" date in Element 4 of the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)).

If the home health agency does not obtain the physician's signature as required by the variance, the agency is providing services without written orders, and such services are non-reimbursable as stated in Wisconsin Admin. Code § DHS 107.02(2)(f). When the physician's dated signature is obtained more than 20 working days after the "From" date listed on the POC for the recertification period, claims for services provided may be reimbursed beginning with the date the agency receives the physician's dated signature on the member's written POC.

Documentation Requirements

The variance is applicable only when the agency has obtained verbal orders and sent the POC to the ordering physician **before** the beginning of the recertification period. The agency must maintain documentation of the date the POC was sent to the ordering physician for their signature.

When the POC is prepared, home health agencies are required to include all the components as instructed in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (09/2015)). The nurse obtaining verbal orders for a recertification period under the variance is required to complete Element 25 as stated in the PA/HCA Completion Instructions after reviewing the POC with the ordering physician. In the context of the instructions for Element 25, the nurse is expected to review the POC with the ordering physician as appropriate to the nurse's license under Wis. Admin. Code § ch. N 6.

Effective Date of Variance

Home health agencies will receive a signed letter from ForwardHealth for their records that includes the effective date and the terms of the discretionary variance.

Unless an agency has received a letter from ForwardHealth granting the variance, the agency is required to comply with the physician signature requirements as stated in Wisconsin Administrative Code or be subject to a potential recovery of any improper payment.

Medicare and Wisconsin Medicaid Enrollment Requirements

Wisconsin Medicaid requires home health agencies to first be enrolled in **Medicare** before enrolling in Wisconsin Medicaid. In addition, an agency is required to maintain **Medicare** enrollment to continue to be eligible for Wisconsin Medicaid enrollment.

Medicare requires a home health agency to complete the OASIS between days 55 and 60 of each 60-day certification period. **Wisconsin Medicaid** requires that the home health agency have the POC signed and dated by the physician prior to the continuation of services past the initial 60-day certification period, as stated in Wis. Admin. Code §§ DHS 107.11(6)(b)4, 107.113(2), and 107.12(1)(d)2.

Because strict enforcement of Wisconsin Administrative Code could result in unreasonable hardship to the home health agency, it is recommended that home health agencies complete the Verbal Orders for Recertification: Home Health Agency Request for Variance of Physician Signature Requirement form to request a 20 working day extension to obtain a physician's signature for verbal orders for POC recertifications.

Topic #2058

Physician Verbal Orders

At times, the physician may give an order verbally.

Verbal Orders for Initial Certification

Verbal orders may be obtained from the attending physician for the initial certification period; however, the attending physician is required to sign and date the POC (plan of care) within 20 working days of the start of care date. To facilitate immediate access to home care services, Wisconsin Medicaid allows home health and PDN (private duty nursing) providers to be reimbursed for services provided under verbal orders. The provider is required to reduce the verbal orders to writing, transmit the orders to the physician immediately, and obtain the physician's signature and date on those orders within 20 working days.

Verbal Orders for Subsequent Certification

Once care has started, **verbal orders may not be obtained for subsequent certification periods**. For ongoing cases, the physician must review, sign, and date renew or (as necessary) revise orders before the end of the certification period for the provider to continue to be reimbursed without interruption after starting care of the member.

The attending physician is required to sign and date the POC prior to the provision of services to the member.

Verbal Orders Within Any Certification Period

An **urgent** situation may prompt the physician to issue verbal orders. Such verbal orders **during** the authorized certification period are the direct result of changes in the patient's condition necessitating an immediate modification to the POC. For example, the member's adverse reaction to a currently prescribed medication or treatment may result in a physician verbally ordering a change to the member's treatment or medication.

When verbal orders are necessary within a certification period, the provider must document the orders, reduce them to writing, and sign and date them. The provider has 10 days from the date the physician gave the orders to obtain the physician's signature and date on those orders.

Topic #1144

Plan of Care Certification Period Versus Prior Authorization Period

The POC (plan of care) certification period and the PA (prior authorization) period refer to two separate time periods.

The requirements for a POC as stated in the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (08/15)) apply to the POC certification period. Regardless of the PA period (which in some cases can be granted for up to a year), the POC must be completed at least every 62 days.

Topic #1143

Provider Stamped Signatures

Under specific conditions, Wisconsin Medicaid accepts providers' stamped signatures on provider orders and plans of care, including attachments that are submitted with requests for PA (prior authorization).

The home care provider (NIP (nurses in independent practice), home health, personal care) is required to meet **both** of these requirements before accepting a provider's stamped signature:

- Obtain a dated statement from the provider with the provider's original signature attesting that they are the only person who possesses the signature stamp and is the only person who uses it.
- Maintain the signed and dated provider statement in the home care provider's records.

Wisconsin Medicaid will consider a stamped signature invalid if these requirements are not met. Payments made by Wisconsin Medicaid to a home care provider that are based on provider orders, authorized PA requests, or plans of care stamped with an invalid or improperly used signature stamp will be **subject to recoupment**. These requirements are similar to those of the federal CMS (Centers for Medicare & Medicaid Services) for providers participating in Medicare.

Signature Stamp Security Awareness for Providers

Providers using a signature stamp should be aware that this method is much less secure than a handwritten signature, creating the potential for misuse or abuse of the stamp. The individual whose name is on the signature stamp is responsible for and attests to the authenticity of the information. Providers should check with their attorneys and malpractice insurers in regard to the use of a signature stamp.

Topic #2057

Provider's Orders and Signature

All home health services require a provider's order or prescription from a provider acting within the scope of their practice. Services provided **before** a provider's order or prescription is obtained will not be reimbursed. The order or prescription shall be in writing or given verbally and later be reduced to writing by the nurse. All orders or prescriptions must be reviewed, signed, and dated by the prescribing provider as stated in Wis. Admin. Code § DHS 107.02(2m).

The initial POC (plan of care) containing the provider's orders must be reviewed, signed, and dated by the provider within 20 working days following the member's start of care. All subsequent POC must be reviewed, signed, and dated by the provider **prior** to the beginning of the new certification period.

Topic #2056

Requirements

The POC (plan of care) must be prescribed by a physician and periodically reviewed by a physician as specified in and supported by all of the following information: Wis. Admin. Code §§ DHS 101.03(124m), 105.16(1), 105.17(2)(b), 105.19(2), 107.02(2m), and 133.20.

The POC must include all of the following information:

- All pertinent diagnoses, including cognitive status
- Type of services and equipment required
- Frequency of visits
- Prognosis
- Rehabilitation potential
- Functional capabilities and limitations
- Activities permitted
- Nutritional requirements
- Medications and treatments
- Any safety measures to protect against injury
- Instructions for timely discharge or referral
- Other items, as appropriate
- Physician review and signature at least every 62 days or when the member's condition changes, whichever occurs first

Wisconsin Admin. Code § DHS 107.02(2m)(b), requires the prescription or order to include the following information:

- The physician's signature and date
- The physician's name, address, and NPI (national provider identifier)
- The member's name, address, and member ID

In addition, POC for PDN (private duty nursing) is required to include the following information:

- Measurable time-specific goals

- Methods for deliverying needed care and an indication of which other professional disciplines, if any, are responsible for delivering the care
- Provisions for care coordination by an RN (registered nurse) when more than one nurse is necessary to staff the member's case
- A description of allergies

POC for PDN services to member's ventilator-dependent for life support shall also include the following information as specified in Wis. Admin. Code § DHS 107.113:

- Ventilator settings and parameters
- Procedures to follow in the event of accidental extubation
- Identification of back-ups in the event scheduled personnel are unable to attend the case
- The name of the RN designated as the member's case coordinator
- A plan for medical emergency to include a description of back-up personnel needed; provision for reliable 24-hour a day, seven days a week emergency service for repair and delivery of equipment; and specification of an emergency power source
- A plan to move the member to safety in the event of fire, flood, tornado warning or other severe weather, or any condition which threatens the member's immediate environment

Other Requirements for Plans of Care

Medically necessary cares as ordered by a physician are to include cares that may be claimed by professional providers **and** cares routinely provided by the family and other volunteer caregivers.

In addition to the elements required on the POC by Wis. Admin. Code § DHS 101.03(124m), agencies should include a brief clinical history and summary of the member's condition to expedite the PA (prior authorization) request. This additional information may decrease the frequency of returned PA requests.

For home health therapy services, Wis. Admin. Code § DHS 101.03(124m) also requires the POC to include specific procedures and modalities to be used and the amount, frequency, and duration of the services.

Topic #2055

Start of Care Date

The start of care date is the date of the member's first billable home care visit. This date remains the same on all subsequent POC (plans of care) until the member is discharged from uninterrupted service.

Private Duty Nursing

Topic #2054

Flexible Use of Weekly Hours

Flexible hours allow PDN (private duty nursing) members and their families to use authorized hours of care over an extended period of time. Hours may be used in varying amounts over the approved period of time to meet the needs of the member and their family. Flexible hours might be used in situations in which a primary caregiver is unable to provide as many hours of care as usual due to an acute illness. Even though flexible use of hours may be approved, the hours must still be medically necessary. Any PDN hours used over those hours approved in the flexibility period are not reimbursable by Wisconsin Medicaid.

Flexibility of hours can be requested to be used in week-long blocks of time. The most common blocks of time are periods of 1, 2, 4, 6, 8, and 9 weeks. Providers should develop a record-keeping system to keep track of the hours of care used. This will help to prevent exceeding the number of hours approved in the period in which flexibility has been authorized.

Although PDN hours may be authorized for up to 52 weeks, the amounts authorized will be divided into 13-week segments. Providers will need to carefully manage use of flexible time to avoid exceeding the amount authorized in the 13-week segment.

Any time flexibility is requested, the date that each flexibility period starts must be clearly specified in the POC (plan of care). Providers using the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)) form should use Element 15 to document the required information pertaining to the flexibility period.

Requesting Flexible Use of Hours

To request flexibility in the use of PDN hours, members and their families should discuss the following with the NIP (nurse in independent practice) and physician:

- Hours of medically necessary care required
- The time period in which flexibility will be used

For example, if it is determined that up to 16 hours per day for seven days per week for a total of 112 hours per week of PDN services are required and the hours will be used flexibly over an eight-week period, the request would read as follows:

PDN RN (registered nurse)/LPN (licensed practical nurse) up to 16 hours per day, seven days per week (total of 112 hours a week). Hours to be used flexibly, one to 24 hours per day, not to exceed 896 hours in an eight-week period all providers combined.

Amending Prior Authorization Requests to Include Flexible Hours

If an existing PA (prior authorization) request has been approved without flexibility, and it is determined that the use of flexible hours would be of benefit, the PAL (prior authorization liaison) should request an amendment to the PA request and obtain new orders from the physician. The amendment must explain the reason flexibility is needed and include the specific date that use of flexible hours will start.

If a change occurs in the member's medical condition or a family medical crisis arises (for example, the extended illness of a primary caregiver), and the coverage for these events cannot be accommodated within the authorized use of the flexible hours during the flexibility period, the PAL should submit a request for additional hours through an amendment to the original PA request. The amendment must explain the reason for the additional hours in detail; however, most events can be accommodated

through the use of flexibility.

Topic #2053

Hours of Private Duty Nursing for Children

To determine the hours of PDN (private duty nursing) care for children, providers should consider the extent to which the family and/or other unpaid caregivers are capable of providing medical cares.

Approval of PDN for 24 hours per day may be considered for children in the following circumstances:

- For short-term care after institutional discharge or after in-home exacerbations with significant medical changes, allowing time to teach the family or caregivers and to stabilize the child and develop routine care techniques
- For short-term care if a single parent or caregiver is hospitalized or if one family member or caregiver is hospitalized and the other is not capable of providing care. PDN for 24 hours per day may fill the gap until other caregivers can be taught cares or until the usual family member or caregiver can resume them
- If the family or caregivers are not **capable** of providing **any** needed cares

PDN may be approved for family member or caregiver work time. For example, if the family member or caregiver works outside the home, a reasonable number of PDN hours may be approved to allow for the family member or caregiver's absence from cares for work and commuting to and from work.

If overnight PDN is medically necessary, PDN may be approved for family or caregivers' sleep time. PDN may be approved for the night shift so the family or caregivers can sleep. Sleep time may be approved during the day if the family member or caregiver works during the night.

PDN may be approved for medically necessary services if the family needs time to perform family or other similar **responsibilities** of the family or caregivers such as grocery shopping, medical appointments, or picking up medical supplies.

PDN may be approved for the child's school hours when it is medically necessary for a nurse to accompany the child to school. In many cases, the child meets enrollment criteria for PDN, but is cared for at school by nurses' aides or laypersons, with a school RN (registered nurse) available as needed.

When determining the number of PDN hours that will be approved, the following elements will be considered:

- The child's school time
- The family or caregivers' work schedule
- Any other pertinent information

Topic #2050

Prior Authorization Is Required

PA (prior authorization) is required for all PDN (private duty nursing) services before the services may be provided. When submitting a PA request for PDN services, the scheduled number of hours requested should reflect the daily care needs of the member. The following should be considered when requesting PDN hours:

- Type of medically necessary skilled service needed
- Stability and predictability of the member's clinical course
- Availability of family/other caregivers

The physician's orders for PDN should be written in hours per day and days per week.

The identified PAL (prior authorization liaison) is the only provider who can submit PA requests, PA amendment requests, and respond to PA return notices.

Topic #13917

Prior Authorization Liaison Changes

If the PAL (prior authorization liaison) on the current PA (prior authorization) is no longer serving as the PAL, it may be necessary to request a new PA to maintain continuity of care. Refer to Changing the Prior Authorization Liaison for the actions required of other PDN (private duty nursing) providers on the case when the identified PAL will no longer be the PAL.

Topic #2049

Requesting Pro Re Nata Hours

Providers can meet the occasional need for additional skilled nursing services by requesting PRN (pro re nata), or "as needed," hours for members who typically require fewer than 24 hours of skilled nursing services per day. When requesting PDN (private duty nursing) PRN hours to use during one or more 13-week segments of authorized PDN services, providers must include physician orders indicating the medical necessity for PDN PRN hours with the PA (prior authorization) and amendment requests. The physician orders should specify the reason(s) PDN PRN hours are necessary, how PDN PRN hours will be used, and the time period(s) when PDN PRN hours likely will be required.

The hours approved for PDN PRN may be used within the 13-week segment(s) where authorized PDN PRN hours are indicated on the decision notice letter. If the member's condition changes and the approved PDN PRN hours are insufficient to meet the member's need for more hours of skilled nursing, the PAL (prior authorization liaison) should submit a request to amend the PA. PRN hours will not be authorized for any 13-week segment that is authorized for flexible use of hours.

Topic #2048

Shared Private Duty Nursing Cases

When home health agencies are case sharing PDN (private duty nursing) services, each provider is responsible for communicating and coordinating the PA (prior authorization) request with other case-sharing providers to assure appropriate care and reimbursement. When PDN providers share a case and at least one of the providers is an NIP (nurse in independent practice), then an NIP who is an RN (registered nurse) on the case must be identified as the care coordinator on the POC (plan of care).

To reduce the chance of PA request returns and expedite the PA process, each provider is required to document specific information about the case. The PA request may be returned if information provided is incomplete and/or inconsistent.

Topic #14057

The Same Plan of Care for Private Duty Nursing

The same PDN (private duty nursing) POC (plan of care) is to be used by all PDN providers sharing the member's case. The POC is developed in consultation with the physician, member, member's family and other providers. All PDN providers shall use the same PDN POC established for the member. The POC must include no less information than is required on the PA/CPA (Prior Authorization/Care Plan Attachment, F-11096 (08/2015)). Each PDN provider sharing the case is required to obtain a

copy of the POC for the effective certification period and maintain the POC for their records.

Topic #14077

When a Home Health Agency is Not the Prior Authorization Liaison

The PDN (private duty nursing) provider who receives the physician's orders to begin providing services to the member is required to sign and date the POC (plan of care) in accordance with the PA/CPA Completion Instructions (Prior Authorization/Care Plan Attachment Completion Instructions, F-11096A (08/15)) in Element 24 and 25 (Signature—Authorized Nurse Completing Form and Date Signed). Before providing services to the member, the home health agency must obtain a copy of the POC for its records. A RN (registered nurse) must read, sign, and date the POC in accordance with the PA/CPA completion instructions for Elements 31 and 32 (Countersignature and Date Signed).

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (06/2024)), and PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)) forms is reviewed during the clerical review of the PA request review process. The following are examples of information verified during the clerical review:

- Billing and/or rendering provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid-enrolled.
- Procedure codes with appropriate modifiers, if required, are covered services.
- Member's name is spelled correctly.
- Member's identification number is correct and corresponds with the member's name.
- Member enrollment is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current provider's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a member, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs through Web PA.

Topic #10517

Private Duty Nursing Clerical Review

For PDN (private duty nursing) services, the PAL (prior authorization liaison) is required to submit all PA/RFs. If clerical errors are identified, the PA request is returned to the PAL for corrections before undergoing a clinical review.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, a PA (prior authorization) request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary," as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to Wis. Admin. Code § DHS 107.02(3)(e).

It is crucial that a provider include adequate information on the PA attachment so that the ForwardHealth consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary," including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to Wis. Admin. Code § DHS 101.03(96m), "medically necessary" is a service under Wis. Admin. Code ch. DHS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes
- Wisconsin Administrative Code
- PA guidelines set forth by Wisconsin DHS (Department of Health Services)
- Standards of practice
- Professional knowledge
- Scientific literature

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

- A copy of the existing PA request, if possible
- A new PA request, including the required attachments and supporting documentation indicating the new billing provider's name and address and billing provider number
- A letter requesting the end-dating of the existing PA request (may be a photocopy) attached to each PA request with the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The provider may want to confer with the member to verify that the services by the previous provider have ended. The new billing provider may include this verification in the letter.)
  - The requested effective date of the change

Topic #453

Examples

Examples of when a new PA (prior authorization) request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (BadgerCare Plus, Medicaid).

If the **rendering** provider indicated on the PA request changes but the **billing** provider remains the same, the PA request remains valid and a new PA request does **not** need to be submitted.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should follow the PA fax procedures.
- Providers should **not** fax the same PA request more than once.
- Providers should **not** fax **and** mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet (F-01176

(12/2025)) includes a confidentiality statement and may be photocopied.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Prior Authorization Fax Procedures

Providers may fax PA requests to ForwardHealth at 608-221-8616. PA requests sent to any fax number other than 608-221-8616 may result in processing delays.

When faxing PA requests to ForwardHealth, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission
- Number of pages, including the cover sheet (The ForwardHealth fax clerk will contact the provider by fax or telephone if all the pages do not transmit.)
- Provider contact person and telephone number (The ForwardHealth fax clerk may contact the provider with any questions about the fax transmission.)
- Provider number
- Fax telephone number to which ForwardHealth may send its adjudication decision
- To: "ForwardHealth Prior Authorization"
- ForwardHealth's fax number at 608-221-8616 (PA requests sent to any other fax number may result in processing delays.)
- ForwardHealth's telephone numbers

For specific PA questions, providers should call Provider Services.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission), or if the PA request is missing information, providers will receive the following by fax from the ForwardHealth fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that ForwardHealth received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to 608-221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at 608-224-6124, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

Topic #10537

Private Duty Nursing Document Sharing

The PAL (prior authorization liaison) is responsible for submitting PA requests to ForwardHealth and for retaining a copy of the submitted PAs and amendments to share with other PDN (private duty nursing) providers. The PAL is required to make available to other PDN providers on the case the PA request and amendment requests for their review.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- View or maintain a PA collaboration (for certain services only).
- Save a partially completed PA request and return at a later time to finish completing it.
- Submit a letter seeking to extend an incomplete PA request.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- Search and view previously submitted PA requests or saved PA requests.
- Print a PA cover sheet.

Submitting PA Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI (National Provider Identifier) requirements, NPI and related data are required on PA requests submitted via the Portal.

Note: If a PA request is urgent, providers must check the Urgent checkbox when submitting the request in the ForwardHealth Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PA requests with a status of "Approved" or "Approved with Modifications."

View or Maintain a PA Collaboration (for Certain Services Only)

A **PA collaborative** will link two or more PA requests for the same member together so providers can easily see and maintain them. Providers may collaborate on PA request submissions and amendments that are submitted for certain services through the Portal.

Any of the following provider types may initiate or add a PA request to a collaborative:

- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Home health agencies
- Personal care agencies

PA requests and amendments will continue to be reviewed individually, regardless of whether they are part of a PA collaborative or not. The denial or modification of one PA request will **not** impact other PA requests in the same collaborative.

Saving Partially Completed PA Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save PA Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does **not** include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Extending PA Requests

If a provider needs more than 30 days to submit the requested information, providers can request an extension by submitting a letter that explains why more time is needed to gather and submit the additional information requested. The letter seeking an extension must be submitted within the initial 30 calendar days of receiving the returned provider review letter.

Instructions for how to submit the letter can be found in the ForwardHealth Provider Portal Prior Authorization User Guide. If a provider wants to submit the letter via mail or fax, the provider must ensure it is received within the 30 days. While mailed or faxed letters are accepted, providers are encouraged to submit the letter via electronic upload.

Providers will be notified in a manner similar to how they submitted their letter, and the new deadline will be included in that notification. Providers who mail their submissions will receive a notification in the mail. Providers who electronically upload their submission will receive a notification in the Portal, etc.

Submitting Completed PA Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a provider is completing a PA request for physician-administered drugs, the Portal will prompt a PA/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA

attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet (F-11159 (07/12)) must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachment(s) on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachment(s) by mail or fax, they will be matched up with the PA/RF (Prior Authorization Request Form, F-11018 (04/2026)) that was completed on the Portal.

Note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA request documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers must submit additional supporting clinical information for PA requests or PA amendment requests electronically.

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (.jpg or .jpeg)
- PDF (.pdf)
- Rich Text Format (.rtf)
- Text File (.txt)
- OrthoCAD (.3dm) (for dental providers)

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with an ".rtf" extension; and PDF files must be stored with a ".pdf" extension. Dental OrthoCAD files are stored with a ".3dm" extension.

Microsoft Word files (.docx or .doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA request or PA amendment request that is in a "Returned — Provider Review" status.
- Submitting a PA amendment request.

If submitting supporting clinical information via mail or fax, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or when the pertinent information is difficult to find.

"Suspended" PA Requests

For PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a PA Request From "Suspended" to "Pending"

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a PA Request in "Suspended" or "Pending" Status

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. PA requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Topic #22417

Prior Authorization Collaboratives

A **PA (prior authorization) collaborative** will link two or more PA requests for the same member together so providers can easily see and maintain them.

Any of the following provider types may initiate or add a PA request to a collaborative:

- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Home health agencies
- Personal care agencies

A provider can indicate their PA request is part of a PA collaborative when submitting their request through the ForwardHealth Portal.

Submissions to PA Collaboratives on the Portal

Providers can submit a PA request as part of a new or existing collaborative on the Portal. The Portal will then assign a nine-digit ID number that the initiating provider can share with collaborating providers. The collaborating providers will use the collaborative ID number to associate their own PA request with the collaborative.

PA collaboratives are available for the following process types for PA requests submitted through the Portal:

- 111–PT (physical therapy)
- 112–OT (occupational therapy)
- 113–SLP (speech and language pathology)
- 120–Home care
- 120–Home health therapy
- 121–Personal care services

Note: Providers that select process type 120 for private duty nursing or process type 142 for behavioral treatment should select None in the Provider Collaboration section of the Initial Information panel when submitting their PA requests through the Portal. If a provider selects New Collaborative or Existing Collaborative in the Provider Collaboration section of the Initial Information panel, ForwardHealth will return the PA request to the provider to resubmit.

After successfully submitting a PA request to a PA collaborative, providers can view all PA requests within it. Through the PA Collaboration panel on the Portal, providers have the option to attest that the PA should remain in the collaborative, or they may choose to opt out of the collaborative.

PA requests and amendments will continue to be reviewed individually, regardless of whether they are part of a PA collaborative or not. The denial or modification of one PA request will **not** impact other PA requests in the same collaborative.

Providers can remove their own PA requests without ending the collaborative if two or more PA requests remain in the collaborative.

All PA requests in a PA collaborative must have start and end dates within the date range of the PA collaborative. If only one PA request remains in the collaborative, the provider must opt out of the collaborative to submit their PA request independently, unless another PA request is added. Providers should refer to the ForwardHealth Provider Portal Prior Authorization User Guide for step-by-step instructions on navigating the Portal for PA collaboratives.

If a provider submits a PA request to be added to an existing PA collaborative, but the collaborative has already been submitted through the Portal, then the provider will get the following message displayed on their screen:

"The Collaborative ID has been submitted and additional PAs may not be added in the WIPortal. Please use the PA Amendment Process to have the PA added to the PA Collaborative ID."

Real-Time Review and Approval Not Available for PA Collaboratives

Certain PT, OT, and SLP, and personal care services are able to access real-time PA review. At this time, the real-time PA review is **not** available for PA collaboratives or the PAs they contain.

Provider Enrollment and Ongoing Responsibilities

8

Archive Date:08/03/2026

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the 1099 mailing address.

Topic #1640

Availability of Records to Authorized Personnel

Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § DHS 106.02(9)(e). DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHS staff member(s).

If Wisconsin Medicaid requires a provider to submit hard copies of records instead of scanning or accepting electronic records during a compliance audit, DHS reimburses providers $0.06 per page. A letter of request for records from DHS will be sent to a provider when records are required, with instructions on how to submit records electronically or if physical records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between DHS and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs (managed care organizations), including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with DHS.

The reproduction of records requested by the PRO (Peer Review Organization) under contract with DHS is reimbursed at a rate established by the PRO.

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with

third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- Is created, received, maintained, or transmitted in any form or media.
- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with their member identification number or Social Security number is an example of PHI.

Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH (Health Information Technology for Economic and Clinical Health) Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 C.F.R. Parts 160 and 164 and § 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the U.S. HHS (Department of Health and Human Services). According to HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in **any** medium, not just electronic data.

Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (for example, rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found on the NIST (National Institute of Standards and Technology) website.

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS website.

Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

Wis. Stat. § 146.836 specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper **and** electronic records are subject to Wisconsin confidentiality laws.

"Personally Identifiable Data" Protected

According to Wis. Stat. § 134.97(1)(e), the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

Actions Required for Proper Disposal of Records

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

Businesses Affected

Wis. Stat.§§ 134.97 and 134.98, governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

Continuing Responsibilities for All Providers After Ending Participation

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to $1.5 million per calendar year
- Jail time
- Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § 34.97(4) imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ 134.97(3), (4) and 146.84.

Topic #201

Financial Records

According to Wis. Admin. Code § DHS 106.02(9)(c), a provider is required to maintain certain financial records in written or electronic form.

Topic #2175

ForwardHealth Review

Home health providers are required to make documentation and financial records available to ForwardHealth for review upon request in accordance with Wis. Admin. Code § DHS 105.16(9). Examples of these types of records include, but are not limited to, the following:

- Clinical notes
- Personnel files
- POCs (plans of care)
- PA (prior authorization) requests
- Progress notes
- Protocols
- Timesheets

As part of a review, ForwardHealth may contact members who have received or are receiving services from a home health provider. Providers are required to provide any identifying information about the member requested by ForwardHealth. ForwardHealth personnel may visit a chosen member with the member's or legal representative's approval. The member has the opportunity to have any person they choose present during the visit. ForwardHealth may investigate any complaint that is received concerning the provision of services by a provider.

Topic #202

Medical Records

A dated clinician's signature must be included in all medical notes. According to Wis. Admin. Code § DHS (Department of Health Services) 106.02(9)(b), a provider is required to include certain written documentation in a member's medical record.

Topic #20998

Documentation of a Face-to-Face Visit for Home Health Services

Providers are required to:

- Follow documentation retention requirements found in Wis. Admin. Code § DHS 105.02.
- Retain copies of the physician prescription and documentation of the face-to-face visit.
- Produce and/or submit the documentation to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet this requirement.

The documentation of the face-to-face visit must be a clearly titled and be a separate and distinct section of (or a clearly titled addendum to) the prescription and must include:

- Date of the face-to-face visit
- Name and credentials of the physician or NPP (non-physician practitioner) who conducted the face-to-face visit
- The clinical findings that support the member's need for home health services
- Signature of the prescribing physician for home health services

Providers are required to maintain the written or electronic documentation in the member's medical record.

Topic #199

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

Per Wis. Stat. § 146.83, providers may charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. This applies regardless of the member's enrollment status on the DOS (dates of service) contained within the health care records.

Per Wis. Stat. § 146.81(4), health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

Providers are limited to charging members enrolled in state-funded health care programs 25% of the applicable fees for providing one set of copies of the member's health care records.

Note: A provider may charge members 100% of the applicable fees for providing a second or additional set of copies of the member's health care records.

Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

For ForwardHealth policy areas where a signature is required, electronic signatures are acceptable as long as the signature meets the requirements. When ForwardHealth policy specifically states that a handwritten signature is required, an electronic signature will not be accepted. When ForwardHealth policy specifically states that a written signature is required, an electronic signature will be accepted.

Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment.

Electronic Signature Definition

An electronic signature, as stated in Wis. Stat. § 137.11(8), is "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

Some examples include:

- Typed name (performer may type their complete name)
- Number (performer may type a number unique to them)
- Initials (performer may type initials unique to them)

All examples above must also meet all of the electronic signature requirements.

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.
- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

When using an electronic signature, all of the following requirements must be met:

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (for example, what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- The provider is required to have current policies and procedures regarding the use of electronic signatures. Wisconsin DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.
- The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 C.F.R. s. 164.308(a)(1).
- The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA

Security Rule.

Electronic Health Record Signature Requirements

An EHR (electronic health record) that utilizes electronic signatures must meet the following requirements:

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 C.F.R. Part 170) and any revisions including, but not limited to, the following:
  - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
  - Record actions related to electronic health information according to the standard set forth in 45 C.F.R. s. 170.210.
  - Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 C.F.R. s. 170.210.
  - Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
  - Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
  - Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT (Information Technology) and/or security/privacy analyst.)
- Ensure the EHR provides:
  - Nonrepudiation (assurance that the signer cannot deny signing the document in the future).
  - User authentication (verification of the signer's identity at the time the signature was generated).
  - Integrity of electronically signed documents (retention of data so that each record can be authenticated and attributed to the signer).
  - Message integrity (certainty that the document has not been altered since it was signed).
  - Capability to convert electronic documents to paper copy. (The paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed.)
- Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a). This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Topic #204

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

According to Wis. Admin. Code § DHS 106.02(9)(d), providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI (protected health information).

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed—according to federal and state regulations—in order to avoid penalties. For more information on the proper disposal of records, refer to Confidentiality and Proper Disposal of Records.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Reviews and Audits

Wisconsin DHS (Department of Health Services) periodically reviews provider records. DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth when releasing billing information or medical claim records relating to charges for covered services except in the following instances:

- When the member is a dual eligible (for example, member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to **Medicare** regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to ForwardHealth.

Request From a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.
2. Send a letter containing the following information to ForwardHealth:
    - Member's name
    - Member's ForwardHealth identification number or SSN (Social Security number), if available
    - Member's DOB (date of birth)
    - DOS (date of service)
    - Entity requesting the records, including name, address, and telephone number

    The letter must be sent to the following address:

Wisconsin Casualty Recovery—HMS
Ste 100
5615 Highpoint Dr
Irving TX 75038-9984

Request From an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked BILLED TO FORWARDHEALTH or TO BE BILLED TO FORWARDHEALTH, with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

   Wisconsin Casualty Recovery—HMS
   Ste 100
   5615 Highpoint Dr
   Irving TX 75038-9984

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO (managed care organization), the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement From a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) § 4311, a dual eligible has the right to request and receive an itemized statement from their Medicare-enrolled health care provider. The Act requires the provider to furnish the requested information to the member. The Act does **not** require the provider to notify ForwardHealth.

Topic #1646

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by Wisconsin DHS (Department of Health Services) or the federal HHS (Department of Health and Human Services) to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under Wisconsin Medicaid confidentiality regulations to report suspected misuse or abuse of program

benefits to DHS, as well as to provide copies of the corresponding patient health care records.

Ongoing Responsibilities

Topic #220

Accommodating Members With Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under Title III of the Americans with Disabilities Act of 1990 (nondiscrimination).

Topic #2174

Availability of Records

All providers are required to maintain a member's original medical record or a copy that can be reproduced.

To ensure continuity of care, providers are strongly encouraged to leave a copy of the member's original medical record in the member's home. Providers should also make a copy of the medical record available at the request of the member or the member's legal representative. Members have a right to a copy of their medical records and are not responsible for maintaining the agency's copy of their records.

Topic #219

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including:

- Title VI and VII of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- Section 504 of the Rehabilitation Act of 1973
- The ADA (Americans With Disabilities Act) of 1990

These laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits
- Segregation or separate treatment
- Restriction in any way of any advantage or privilege received by others (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access

- Not providing translation of vital documents to the LEP groups who represent 5% or 1,000, whichever is smaller, in the provider's area of service delivery

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 C.F.R. Part 91.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the Wisconsin DHS (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ fewer than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers without internet access can get copies of the DHS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by calling the Affirmative Action and Civil Rights Compliance Officer at 608-266-9372. Providers may also write to the following address:

AA/CRC Office
201 E Washington Ave Room B300
PO Box 7850
Madison WI 53707-7850

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or Tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program
- Providing services in a manner different from those provided to others under the program
- Aggregating or separately treating clients
- Treating individuals differently in eligibility determination or application for services
- Selecting a site that has the effect of excluding individuals
- Denying an individual's participation as a member of a planning or advisory board
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the

accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans With Disabilities Act of 1990

Under Title III of the ADA of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make their goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (to the extent that needed changes can be accomplished without much difficulty or expense)
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the act's requirements.

Topic #198

Contracted Staff

Under a few circumstances (for example, personal care, case management services), providers may contract with non-Medicaid-enrolled agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractors' services.

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code

- ForwardHealth Updates
- The Online Handbook

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Topic #2173

Discharge of Members

A home health agency may not discharge a member for any reason until the agency has discussed the details of the discharge with the member, or the member's legal representative, and the member's physician. Refer to Wis. Admin. Code § DHS 133.09, for details concerning the discharge of members.

Topic #2172

Distribution of Private Duty Nursing Information

Providers of PDN (private duty nursing) services acting as the PAL (prior authorization liaison) are strongly encouraged to photocopy and distribute the brochure titled Private Duty Nursing — A Guide for Wisconsin Medicaid and BadgerCare Plus Members and Their Families (P-01122 (03/10)) to all members and their families.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients
- Complying with all state and federal laws related to ForwardHealth
- Obtaining PA (prior authorization) for services, when required
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service
- Maintaining accurate medical and billing records
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment
- Billing only for services that were actually provided
- Allowing a member access to their records
- Monitoring contracted staff
- Accepting Medicaid reimbursement as payment in full for covered services
- Keeping provider information (for example, address, business name) current
- Notifying ForwardHealth of changes in ownership
- Responding to Medicaid revalidation notifications
- Safeguarding member confidentiality
- Verifying member enrollment
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

  Note: Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

- Business name
- Contact name
- Federal Tax ID number (IRS (Internal Revenue Service) number)
- Group affiliation
- Licensure
- NPI
- Ownership
- Professional certification
- Provider specialty
- Supervisor of nonbilling providers
- Taxonomy code
- Telephone number, including area code

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement
- Misdirected payment
- Claim denial
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address

Entering new information on a claim form or PA request is **not** adequate notification of change.

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (for example, Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The Account User Guide provides specific information about switching organizations.

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical

address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- 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 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43–49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. DHS 101, 102, 103, 104, 105, 106, 107, and 108

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.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by Wisconsin DHS (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) is directly responsible for managing these programs.

Topic #2176

The following laws and regulations provide the legal framework for the program requirements of home health agencies:

- Wis. Stat. §§ 49.46(2)(b)6m, 49.47(6)(a)1, 448.05, and 448.07
- Wis. Admin Code ch. DHS 133 and §§ DHS 105.16, 107.11, 107.113, 107.12, and N 6.03 and N 6.04

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (for example, hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as prescribing/referring/ordering providers, if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the demographic maintenance tool. After entering information for their new license(s), some providers (for example, out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (for example, grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #15157

Recovery Audit Contractor Audits

The ACA (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and HDAP (Wisconsin HIV Drug Assistance Program).

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The Wisconsin DHS (Department of Health Services) OIG (Office of Inspector General) investigates fraud and abuses including the following:

- Billing Medicaid for services or equipment that were not provided
- Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), or FoodShare
- Trafficking FoodShare benefits

- Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

Wisconsin Stat. § 49.49 defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

Reporting Suspected Fraud and Abuse

Those who suspect any form of fraud, waste, or abuse of a program by providers, trading partners, billing services, agencies, or recipients of any government assistance program are required to report it. Those reporting allegations of fraud and abuse may remain anonymous. However, not providing contact information may prevent OIG from fully investigating the complaint if questions arise during the review process.

If a provider suspects that someone is committing fraudulent activities or is misusing their ForwardHealth card, the provider is required to notify ForwardHealth by one of the following methods:

- Going to the OIG fraud and abuse reporting website
- Calling the DHS fraud and abuse hotline at 877-865-3432

The following information is helpful when reporting fraud and abuse:

- A description of the fraud, waste, and/or abuse, including the nature, scope, and timeframe of the activity in question (The description should include sufficient detail for the complaint to be evaluated.)
- The names and dates of birth (or approximate ages) of the people involved, as well as the number of occurrences and length of the suspected activity
- The names and date(s) of other people or agencies to which the activity may have been reported

After the allegation is received, DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.

Topic #14358

Requirements for Home Health and Personal Care Agencies to Report Personnel Information to ForwardHealth

ForwardHealth has implemented requirements for home health and personal care agencies to report personnel information to ensure appropriate licensing and to prevent waste, fraud, and abuse.

Reporting Requirements for Providers Enrolling in Wisconsin Medicaid

ForwardHealth requires home health agencies and personal care agencies, including out-of-state and border status providers, enrolling in Wisconsin Medicaid to report specific information regarding the following personnel who are employed by, contracted by, or employed by an agency under contract with the home health and personal care agency:

- LPNs (Licensed practical nurses)

- RNs (Registered nurses)
- SLPs (Speech and language pathologists)
- OTs (Occupational therapists)
- OT assistants
- PTs (Physical therapists)
- PT assistants
- Home health aides
- Personal care workers

Home health and personal care agencies are required to report information on the personnel listed above, even if the employee or contractor is also a separately enrolled Medicaid provider. Medicaid-enrolled home health and personal care agencies will have to report the following information to ForwardHealth:

- First name, middle initial, and last name
- DOB (Date of birth)
- SSN (Social Security number)
- Employment effective date
- Employment end date (when applicable)
- License information (not required for home health aides or personal care workers)

Note: Providing personnel SSNs is voluntary; however, any person employed by, contracted by, or employed by an agency under contract with a Wisconsin Medicaid home health and/or personal care agency who provides home health and/or personal care services to members is required to supply a valid SSN in order for Wisconsin Medicaid to conduct screenings via the following databases:

- The SSA's (Social Security Administration) Death Master File
- OIG (Office of the Inspector General) LEIE (List of Excluded Individuals/Entities)
- The EPLS (Excluded Parties List System)

When applicable, Wisconsin Medicaid will also conduct license verification. ForwardHealth is prohibited by law from reimbursing for services provided by anyone who is included on the SSA Death Master File, the OIG LEIE, or the EPLS for services provided by an unlicensed practitioner.

Services provided by home health agency and personal care agency workers whose SSN are not on file with ForwardHealth or by workers who do not pass the screening process are not reimbursable.

Personnel Screening During New Enrollment

When completing the Medicaid enrollment process for the first time, home health and personal care agencies will be required to enter their workers' information for screening. After entering a worker's information, the provider will see a pass status on the Portal panel if the screening was successfully completed. In addition, the worker's name and status will be included on the enrollment report that the agency will be instructed to print after completing the enrollment process.

If there is any discrepancy or problem during the screening, the worker will not appear in the list, and the information will be automatically forwarded to ForwardHealth for manual review. If the worker does not pass the screening, a letter will be mailed to the agency indicating the name of the worker and information regarding why the worker did not pass the screening.

Updating Personnel Information via the Demographic Maintenance Tool

Once enrolled in Wisconsin Medicaid, home health and personal care agencies, including out-of-state and border status providers, are required to report and maintain personnel information using the demographic maintenance tool. Each agency is responsible for designating agency personnel to update and maintain personnel information.

Note: In order to protect the individual's personal information, the SSN (Social Security number) and DOB (date of birth) will not display after the first time the information is entered into the demographic maintenance tool fields.

ForwardHealth requires home health agencies and personal care agencies to report personnel information for any of the following qualifying events:

- The person becomes an employee of the enrolled Medicaid provider.
- The contract agency begins its contract with the enrolled Medicaid provider.
- A person begins employment with the contract agency.
- A person begins their contract with the enrolled Medicaid provider.

If a worker passes the screening, their name will appear in the list of workers panel, and the agency will receive a message that the worker passed the screening.

If there is any discrepancy or problem during the screening, the worker's name will not appear in the list, and the information will be automatically forwarded to ForwardHealth for manual review. If the worker passes the manual screening, their name will appear in the list within 10 business days. If the worker does not pass the screening, a letter will be mailed to the agency indicating the name of the worker and information regarding why the worker did not pass the screening.

Home health agencies and personal care agencies may submit claims for services beginning on the date the personnel information was reported to ForwardHealth only for services provided by persons who passed the screening on or before the DOS (date of service).

If the person does not pass the screening, the home health or personal care agency may not submit claims for services provided by that person to Wisconsin Medicaid or BadgerCare Plus members.

An agency should report the employment end date immediately after an employee resigns or the agency or contract agency terminates the employee.

Topic #1711

Submitting Cost Reports

The WIMCR (Wisconsin Medicaid Cost Reporting) initiative is a cost-based payment system for counties enrolled as Medicaid providers of community-based services that provides additional funding for Wisconsin Medicaid while remaining cost neutral for counties.

All counties enrolled as Medicaid providers of community-based services are required to submit cost reports to ForwardHealth. Cost reports are required under WIMCR for the following services provided and billed to Wisconsin Medicaid by county providers:

- Case management services
- Child/adolescent day treatment
- Community support program services
- Home health services
- Medical day treatment services
- Mental health crisis intervention services
- Outpatient mental health and substance abuse services, including evaluation, psychotherapy, and substance abuse counseling and intensive in-home mental health services for children under HealthCheck
- Outpatient mental health and substance abuse services provided in the home and community (The non-federal share of this service is provided by the county.)

- Personal care services
- PNCC (Prenatal Care Coordination) services
- Substance abuse day treatment

If Wisconsin Medicaid is not billed by the county for case management services, no cost report is required.

Cost Reporting Web Tool

Counties are required to submit cost reports online by using the WIMCR web tool. After registering on the website, the user will be directed to the WIMCR home page where the following information is located:

- Certification of Medicaid Operating Deficit and Application for Distribution of Federal Financial Participation
- Past WIMCR Cost Reports
- The WIMCR Cost Report Instruction Manual
- Other WIMCR reference documents

Topic #2171

Written Statement of Member Rights

In accordance with Wis. Admin. Code § DHS 133.08(2), all home health agencies are required to furnish a written statement of member rights to the members they serve. Providers are required to share the statement with the member or their legal representative prior to providing services.

The member or legal representative is required to acknowledge the receipt of the statement of member rights in writing, and the statement must be included in the member's medical record.

Each member of home health services has rights that include, but are not limited to, the following:

- Being fully informed of all of their rights
- Being fully informed of all rules and regulations governing member responsibilities
- Being informed of all services and any changes in these services as they occur
- Being informed of all charges for which the member may be responsible
- Being fully informed of one's own health condition, unless medically contraindicated
- Participating in the planning of services, including referral to health care institutions or other agencies
- Refusing to participate in experimental research
- Refusing treatment to the extent permitted by law and being informed of the medical consequences of such refusal
- Confidential treatment of personal and medical records and approving or refusing their release to any individual outside the agency except in the case of transfer to a health care facility or as required by law or third-party payment contract
- Being treated with consideration, respect, and full recognition of dignity and individuality
- Being taught the treatment that is required so that the member can, to the extent possible, help themselves (Family, other persons living with the member, or other parties designated by the member will also be taught the treatment so that these persons can understand and assist the member.)
- Complaining about the care that was provided or not provided and seeking resolution of the complaint without fear of recrimination

Provider Enrollment

Topic #2181

A Comprehensive Overview

BadgerCare Plus and Medicaid home health services refer to policies for the following services provided by home health agencies:

- Home health skilled nursing services
- PDN (private duty nursing) services
- Home health aide services
- Home health therapy services
- DME (durable medical equipment)
- DMS (disposable medical supplies)

Home health agencies enrolled to provide personal care services are also required to follow the policies and procedures as stated in the Personal Care service area.

Topic #3969

Categories of Enrollment

Wisconsin Medicaid enrolls providers in three billing categories. Each billing category has specific designated uses and restrictions. These categories include:

- Billing and rendering provider
- Rendering-only provider
- Billing-only provider (including group billing)

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the Provider Enrollment Information home page to identify which category of enrollment is applicable.

Billing and Rendering Provider

Enrollment as a billing and rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering-Only Provider

A provider enrolled as a rendering-only provider who practices under the professional supervision of another provider. Rendering-only providers enrollment cannot submit claims to ForwardHealth directly. Instead, they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Billing-only providers can submit claims to ForwardHealth while a separate rendering-only provider is required on those claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

In 2010, the federal government signed into law the ACA (Affordable Care Act), also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth worked toward ACA compliance by implementing requirements for providers and provider screening processes. To meet federally mandated requirements, ForwardHealth implemented changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the federal CMS (Centers for Medicare & Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during enrollment, re-enrollment, and revalidation.
- Certain provider types are subject to an application fee. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- Providers are required to undergo revalidation every three years.
- All physicians and other professionals who prescribe, refer, or order services and other providers who receive Medicaid funds are required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.
- Providers are required to submit personal information about all persons with an ownership or controlling interest, agents, and managing employees at the time of enrollment, re-enrollment, and revalidation.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be enrolled in Wisconsin Medicaid. Information is available regarding the enrollment options for in-state emergency providers and out-of-state providers.

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a professional dispensing fee reimbursement rate of $10.51.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and HDAP (Wisconsin HIV Drug Assistance Program) information. Future changes to policies and procedures are published in ForwardHealth Updates.

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- **Practice location address and related information.** This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.
- **Mailing address.** This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- **PA (prior authorization) address.** This address is where ForwardHealth will mail PA information.
- **Financial addresses.** Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service website.

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type
- Provider terms of reimbursement
- Disclosure information
- Category of enrollment
- Additional documents needed (when applicable)

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information
- Regulations and forms
- Provider type-specific enrollment information
- In-state and out-of-state emergency enrollment information
- Contact information

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #22257

Providers Have 35 Days to Report a Change in Ownership

Medicaid-enrolled providers are required to notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the CMS (Centers for Medicare & Medicaid Services) Final Rule 42 C.F.R. § 455.104(c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. § 455.104(e).

Note: For demographic changes that do not constitute a change in ownership, providers should update their current information using the demographic maintenance tool.

Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new Medicaid provider enrollment application on the Portal.
- Upload a change in ownership notification as an attachment when completing a new Medicaid provider enrollment

application on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (NPI (National Provider Identifier) or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

These provider types require Medicare enrollment and/or Wisconsin DQA (Division of Quality Assurance) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- CHCs (Community health centers)
- ESRD (End-stage renal disease) services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- RHCs (Rural health clinics)
- Tribal FQHCs (federally qualified health centers)

Events That ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

These events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
  - Sole proprietorships
  - Corporations
  - Partnerships
  - LLCs (Limited liability companies)
- Change of name and TIN (Tax Identification Number) associated with the provider's submitted enrollment application (for example, EIN (Employer Identification Number))
- Change (addition or removal) of names identified as owners of the provider

Examples of a Change in Ownership

Examples of a change in ownership include:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate, and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

End Date of Previous Owner's Enrollment

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS (Department of Health Services) is notified of a change in ownership, the original owner's enrollment will automatically be end-dated.

Repayment Following a Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them. If the previous owner does not repay ForwardHealth for any erroneous payments or overpayments, the new owner's application will be denied.

If necessary, ForwardHealth will hold responsible for repayment the provider to whom a transfer of ownership is made prior to the final transfer of ownership. The provider acquiring the business is responsible for contacting ForwardHealth to ascertain if they are liable under this provision.

The provider acquiring the business is responsible for full repayment within 30 days after receiving such a notice from ForwardHealth.

Providers may send inquiries about the determination of any pending liability to the following address:

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to Wis. Stat. § 49.45(21) for complete information.

Automatic Recoupment Following a Change in Ownership

ForwardHealth will automatically recover payments made to providers whose enrollment has ended in the ForwardHealth system due to a change in ownership. This automatic recoupment for previous owners occurs about 45 days after DHS is notified of the change in ownership. The recoupment will apply to all claims processed with DOS (Dates of Service) after the provider's new end date.

New Prior Authorization Requests Must Be Submitted After a Change in Ownership

Medicaid-enrolled providers are required to submit new PA (prior authorization) requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request.

The provider is required to send this information to ForwardHealth with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- A letter requesting to end date the original PA request (may be a photocopy), which should include the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the

letter.)
- The requested effective date of the change

Submitting Claims After a Change in Ownership

The provider acquiring the business may submit claims with DOS on and after the change in ownership effective date.

Additional information on submission of timely filing requests or adjustment reconsideration requests is available.

How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has DOS from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

How to Bill for a Nursing Home Stay That Spans a Change in Ownership

When a change in nursing home ownership occurs, use the NPI that is current on the date of discharge. For example, a change in ownership occurs on July 1. A nursing home patient stay has DOS from June 26 to July 2. The nursing home submits the claim using the NPI effective July 1.

For Further Questions

Providers with questions about changes in ownership may call Provider Services.

Topic #2177

Termination of Provider Enrollment

A provider's Wisconsin Medicaid enrollment may be terminated for failure to comply with the enrollment and covered services requirements specified in the following:

- Wisconsin Admin. Code § DHS 105.16
- Wisconsin Admin. Code § DHS 107.11
- Wisconsin Admin. Code § DHS 107.113
- Wisconsin Admin. Code § DHS 107.12

In addition, a provider's Medicaid enrollment may be terminated for any of the reasons described in Wis. Admin. Code § DHS 106.06.

In accordance with Wis. Admin. Code § DHS 106.065(1)(c), providers terminated for failure to comply with these requirements have 30 calendar days from the date of termination of enrollment to make alternative care arrangements for BadgerCare Plus and Medicaid members under their care prior to the effective date of termination. After the 30-day period, payment for services will stop, except for payments to providers terminated in situations where the member's health and/or safety is in immediate jeopardy.

At least 15 working days advance notice of termination is required to be provided to the provider, except in situations where the member's health and/or safety is in immediate jeopardy. In these situations, at least five calendar days advance notice is provided to the provider, as specified in Wis. Admin. Code § DHS 106.065(1)(b). As determined by BadgerCare Plus and Medicaid, alternative care arrangements may also be made in order to provide continuity of care and protect the member, as stated in Wis. Admin. Code § DHS 106.065(1)(c).

Topic #14317

Terminology to Know for Provider Enrollment

ForwardHealth adopted terminology due to the ACA (Affordable Care Act), which is included in the following table. This terminology is useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. § s. 455.101 for more information.

Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) • Any Medicare intermediary or carrier • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling 5% or more in a disclosing entity • Has an indirect ownership interest equal to 5% or more in a disclosing entity • Has a combination of direct and indirect ownership interest equal to 5% or more in a disclosing entity • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or asset of the disclosing entity • Is an officer or director of a disclosing entity that is organized as a corporation • Is a person in a disclosing entity that is organized as a partnership

Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the federal CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid revalidates providers every three years.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES website. The federal CMS (Centers for Medicare and Medicaid Services) website includes more information on Type 1 and Type 2 NPIs.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

Non-Healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool. Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service website.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a member under limited circumstances.
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (for example, the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS (Enrollment Verification System) methods, including calling Provider Services.

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to Wis. Admin. Code § DHS 106.05.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a Wisconsin DHS (Department of Health Services) action or inaction for which due process is

required under Wis. Stat. ch. DHS 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest DMS (Division of Medicaid Services)'s notice of intent to recover payment (for example, to recoup for overpayments discovered in an audit by DMS) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting DHS's decision to withhold payment.

Refer to Wis. Admin. Code ch. DHS 106 for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and DMS (Division of Medicaid Services) will consider applications for, a discretionary waiver or variance of certain rules in Wis. Admin. Code chs. DHS 102, 103, 104, 105, 107, and 108. Rules that are not considered for a discretionary waiver or variance are included in Wis. Admin. Code § DHS 106.13.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in Wis. Admin. Code ch. DHS 107.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to DMS. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

DMS may also require additional information from the provider or the member prior to acting on the request.

Application

DMS may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, federal CMS (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to Wis. Admin. Code § DHS 106.08(3), Wisconsin DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that DHS may apply include the following:

- Review of the provider's claims before payment
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization
- Restricting the provider's participation in BadgerCare Plus
- Requiring the provider to correct deficiencies identified in a DHS audit

Prior to imposing any alternative sanction under this section, DHS will issue a written notice to the provider in accordance with Wis. Admin. Code § DHS 106.12.

Any sanction imposed by DHS may be appealed by the provider under Wis. Admin. Code § DHS 106.12. Providers may appeal a sanction by writing to DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

Wisconsin DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to Wis. Admin. Code § DHS 106.06.

The suspension or termination may occur if both of the following apply:

- DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose enrollment is terminated by DHS. Refer to Wis. Admin. Code § DHS 106.07 for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of enrollment with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Topic #213

Sanctions for Collecting Payment From Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC § 1320a-7b(d) or Wis. Stat. § 49.49(3m).

There may be narrow exceptions on when providers may collect payment from members.

Topic #214

Withholding Payments

Wisconsin DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, DHS finds reliable evidence of fraud or willful misrepresentation.

Reliable evidence of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Reimbursement

9

Archive Date:08/03/2026

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (for example, any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copay or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or HDAP (Wisconsin HIV Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (for example, balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or HDAP.

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

EFT (Electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers
- Out-of-state providers
- Out-of-country providers
- SMV (Specialized medical vehicle) providers during their provisional enrollment period

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk who has been assigned the EFT role on the Portal may complete the EFT enrollment information.
- Organizations can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their RA (Remittance Advice) as they do currently.

Refer to the Electronic Funds Transfer User Guide on the User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into Active status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (for example, a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

Fee Schedules

Maximum allowable fee information is available on the Max Fee Schedules page of the ForwardHealth Portal in the following forms:

- An interactive maximum allowable fee schedule
- Downloadable fee schedules by service area only in TXT (text) or CSV (comma separated value) files

Policy information is not displayed in the fee schedules. Providers should refer to their specific service area in the Online Handbook for more information about coverage policy related to a specific procedure code.

Certain fee schedules are interactive. On the interactive fee schedule, providers have more search options for looking up some coverage information, as well as the maximum allowable fees, as appropriate, for reimbursable HCPCS (Healthcare Common Procedure Coding System), CPT (Current Procedural Terminology), or CDT (Current Dental Terminology) procedure codes for most services.

Providers have the ability to independently search by:

- A single HCPCS, CPT, or CDT procedure code
- Multiple HCPCS, CPT, or CDT procedure codes
- A pre-populated code range
- A service area (Service areas listed in the interactive fee schedule more closely align with the provider service areas listed in the Online Handbook, including the WCDP (Wisconsin Chronic Disease Program) programs and WWWP (Wisconsin Well Woman Program).)

The downloadable fee schedules, which are updated monthly, provide basic maximum allowable fee information by provider service area.

Through the interactive fee schedule, providers can export their search results for a single code, multiple codes, a code range, or by service area. The export function of the interactive fee schedule will return a .zip file that includes seven CSV files containing the results.

Note: The interactive fee schedule will export all associated information related to the provider's search criteria except the procedure code descriptions.

Providers may call Provider Services in the following cases:

- The ForwardHealth Portal is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #2024

Home health aide services, home health skilled nursing services, and home health therapy services are reimbursed according to a maximum allowable fee per visit. PDN (private duty nursing) services are reimbursed based on an hourly maximum allowable fee.

Home health agencies are reimbursed only for the specific services for which they are licensed.

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met **prior** to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a **written** statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Topic #538

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copay, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copays required by other health insurance sources. Instead, the provider should collect from the member **only** the Medicaid or BadgerCare Plus copay amount indicated on the member's remittance information.

Topic #224

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, **except** for the following:

- Required member copays for certain services.
- Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and

if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment.

Copayment

Topic #233

Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5% of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is exempt from paying copays or has reached their monthly copay limit by accessing the Enrollment Verification System and receiving the message "No Copay" in response to an enrollment query.

Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit. **Providers may not collect copays from members who have met their individual monthly copay limit.**

Topic #2023

Prohibited

Home health service providers are prohibited from collecting copay from BadgerCare Plus and Medicaid members for home health services, PDN (private duty nurse) services provided to members under age 19, and personal care services.

Topic #237

Refund/Collection

If a provider collects a copay before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copay amount to the member.

If BadgerCare Plus deducts less copay than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copay than the member paid, the provider may collect the remaining amount from the member.

Topic #239

Requirements

Federal law permits states to charge members a copay for certain covered services. Providers are required to request copays from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus member who fails to make a copay.

Wis. Stat. § 49.45(18) requires providers to make a reasonable attempt to collect copay from the member unless the provider determines that the cost of collecting the copay exceeds the amount to be collected.

Payer of Last Resort

Topic #242

Instances When Medicaid is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are **not** the payer of last resort for members who receive coverage from certain governmental programs, such as:

- Birth to 3
- Crime Victim Compensation Fund
- GA (General Assistance)
- HCBS (Home and Community-Based Services) waiver programs:
  - CLTS (Children's Long-Term Support Program)
  - Family Care
  - Family Care Partnership
  - IRIS (Include, Respect, I Self-Direct)
- IDEA (Individuals with Disabilities Education Act)
- Indian Health Service
- Maternal and Child Health Services
- WCDP (Wisconsin Chronic Disease Program):
  - Adult Cystic Fibrosis
  - Chronic Renal Disease
  - Hemophilia Home Care

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Topic #251

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans
- Commercial managed care plans
- Medicare supplements (for example, Medigap)
- Medicare
- Medicare Advantage and Medicare Cost plans
- TriCare
- CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration)
- Other governmental benefits

Topic #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Topic #255

Primary and Secondary Payers

The terms primary payer and secondary payer indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Topic #2022

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Reimbursement is also not available for noncovered services.

Home health agencies may not receive Medicaid reimbursement for the services stated in Wis. Admin. Code § DHS 107.11(5). These services include, but are not limited to, the following:

- Services that are not medically necessary as defined in Wis. Admin. Code § DHS 101.03(96m), including, but not limited to, services that are:
  - Duplicative with respect to other services provided.
  - Provided solely for the convenience of the member, member's family, or a provider.
  - Not cost-effective compared to an alternative medically necessary service that is reasonably accessible to the member.
- Any services that do not make effective and appropriate use of available services.
- More than one initial visit per day by a home health skilled nurse, home health aide, physical or occupational therapist, or speech and language pathologist.
- Services requiring PA (prior authorization) that are provided without PA.
- Supervision of the member when supervision is the only service provided at the time. This includes supervision provided to give the primary caregiver a respite from care.
- Hospice care provided under Wis. Admin. Code § DHS 107.31.
- Mental health and substance abuse services provided under Wis. Admin. Code §§ DHS 107.13(2), (3), (3m), (4), and (6).
- Medication administration by a PCW (personal care worker) or a home health aide that has not been delegated by an RN (registered nurse) according to the relevant provisions of Wis. Admin. Code ch. DHS 133.
- Home health skilled nursing services contracted by a home health agency unless the requirements of Wis. Admin. Code § DHS 133.19, are met and approved.
- Home health services to a member who is eligible for covered services under the Medicare program or any other insurance held by the member.
- Parenting.
- Services to other members of the member's household.
- Services provided to a member by legally responsible relatives in accordance with Wis. Stat. § 49.90.
- Skilled nursing visits solely for the purpose of ensuring that a member who has a demonstrated history of noncompliance over 30 days complies with the medications program, as required by Wis. Admin. Code § DHS 107.11(5)(L)1.
- A skilled nursing visit to ensure compliance with the medication regimen of an adult member who has a demonstrated history of non-compliance over 30 days.
- Medication administration to a minor child unless the parents are unable to administer the medication.
- A skilled nursing visit to administer medication to an adult member who is capable, but chooses not to, self-administer the medication. A member is considered "capable" if the member has no physicial or mental condition that would prevent the member from self-administering the medication.
- Activities for the general welfare of a member, for example, general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy.
- Therapy that requires only the use of equipment without the skills of a therapy provider is not covered.
- Group therapy.
- When a face-to-face visit does not occur or does not occur within the specified timeframes for impacted services that do

not require PA, the reimbursement will be subject to recovery during a provider audit.

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (for example, a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Resources

10

Archive Date:08/03/2026

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

Professional Field Representatives

Professional field representatives, also known as field representatives, are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

The field representatives are assigned to specific regions of the state. Most professional field representatives can address inquiries for all provider types. However, certain dedicated professional field representatives are assigned to the following:

- Adult long-term care
- Dental providers
- Milwaukee County
- PNCC (Prenatal care coordination) and CCC (child care coordination)
- WWWP (Wisconsin Well Woman Program)

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- Conducting provider training sessions throughout the state
- Providing training and information for newly enrolled providers and/or new staff
- Participating in professional association meetings

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the ForwardHealth Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (for example, phone or written

correspondence)
- Referrals by a Provider Services phone correspondent
- Complex issues that require extensive explanation

At times, professional field representatives work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to Member Services.

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. Discuss the appropriate method of sending emails with your assigned field representative to ensure secure transmission of information.

Providers or their representatives should have the following information ready when they contact their professional field representative:

- Name or alternate contact
- County and city where services are provided
- Name of facility or provider whom they are representing
- NPI (National Provider Identifier) or provider number
- Phone number, including area code
- A concise statement outlining concern
- Days and times when available

For questions about a specific claim, providers should also include the following information:

- Claim number
- DOS (date of service)

Topic #474

Provider Services

Providers should call Provider Services to answer enrollment, policy, and billing questions. Members should call Member Services for information. Members should **not** be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services Call Center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submission
- Provider enrollment
- Member enrollment
- COB (coordination of benefits) (for example, verifying a member's other health insurance coverage)
- Assistance with completing forms
- Assistance with remittance information and claim denials
- Policy clarification
- PA (prior authorization) status
- Claim status

- Verifying covered services

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID
- Member name and ID
- Claim ICN (internal control number)
- PA number
- DOS (date of service)
- Amount billed
- RA (Remittance Advice)
- Procedure code of the service in question
- Reference to any provider publications that address the inquiry

Call Center Representatives

The ForwardHealth call center representatives are organized to respond to phone calls from providers. Representatives offer assistance and answer inquiries specific to the program (for example, Medicaid, WCDP, or WWWP) or to the service area (for example, pharmacy services, hospital services) in which they are designated.

In addition to trained call center representatives, Provider Services employs an automated tool for assisting callers. The virtual agent is available 24 hours a day, seven days a week to answer questions that do not require a call center representative, such as inquiries related to:

- Claim status
- PA status
- Provider payment status
- Member enrollment verification

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m. – 4 p.m. (Central time), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the Contact Us link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry (F-01170 (07/2012)) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth

Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	**www.forwardhealth.wi.gov/**	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**800-947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries: - Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	**800-947-9627**	**Call center representatives: Monday – Friday, 7 a.m. – 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week**
To assist providers in the following programs: - BadgerCare Plus - Medicaid - SeniorCare - Family Care - Family Care Partnership - IRIS (Include, Respect, I Self-Direct) - PACE (Program of All-Inclusive Care for the Elderly) - HDAP (Wisconsin HIV Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid		

- WWWP (Wisconsin Well Woman Program)

ForwardHealth Portal Helpdesk	**866-908-1363**	**Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**866-416-4979**	**Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)***
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following: - Electronic transactions - Companion documents - PES (Provider Electronic Solutions) software		
Managed Care Provider Appeals	**800-760-0001, Option 1**	**Monday – Friday, 7 a.m. – 6 p.m. (Central time)***
To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**800-760-0001**	**Monday – Friday, 7 a.m. – 6 p.m. (Central time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**800-362-3002**	**Monday – Friday, 8 a.m. – 6 p.m. (Central time)***
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		
Wisconsin HIV Drug Assistance Program	**800-991-5532**	**Monday – Friday, 8 a.m. – 4:30 p.m. (Central time)***
To assist HDAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (for example, exchange interfaces, transaction administration, and data preparation)
- Instructions for constructing the technical component of submitting or receiving electronic transactions (for example, claims, RA (Remittance Advice), and enrollment inquiries)

Companion guides and payer sheet do **not** include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (for example, identification information, testing, and exchange preparation)
- Transaction administration (for example, tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk)
- Transaction formats

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an email to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully

(for example, claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software
- Secure web, using an internet service provider and a personal computer with a modem, browser, and encryption software
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Eligibility & Benefit Inquiry and Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, HDAP (Wisconsin HIV Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

The EDI (Electronic Data Interchange) Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) Version D.0 Payer Sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Eligibility & Benefit Inquiry and Response): The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response): The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review — Request for Review and Response): The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice): The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim): The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Acknowledgment for Health Care Insurance): The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 interChange Acknowledgment: The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy claims: The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Acknowledgment for Health Care Insurance) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A trading partner is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s)
- State-contracted MCO (managed care organization) enrollment
- Medicare enrollment
- Limited benefits categories
- Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- Exemption from copays for BadgerCare Plus members

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers
- Personal computer software
- Internet

Vendors sell magnetic stripe card readers, personal computer software, internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are **not** required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction 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. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) 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 enrollment verification vendors provide real-time access to enrollment from the EVS through the internet.

Topic #4903

Copay Information

No Copay

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copays for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates
- The message, No Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates

Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the $8 non-emergent copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates
- The message, Member Eligible for Non-Emergent Copay or Eligible for Non-Emergent Copay

The messages Member Eligible for Non-Emergent Copay and Eligible for Non-Emergent Copay indicate that a member is a BadgerCare Plus childless adult, and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should **always** verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, Wisconsin's AVR (Automated Voice Response) system
- Commercial enrollment verification vendors
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions
- Provider Services

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying their enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).

- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copays (BadgerCare Plus and Medicaid members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the print screen function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a From DOS (date of service) and a To DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a From DOS is the earliest date for which the provider is requesting enrollment information and the To DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

- The From DOS is the earliest date the provider requires enrollment information.
- The To DOS must be within 365 days of the From DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card or displays a digital ForwardHealth Card on the MyACCESS app.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a 0 at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when they are not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under BadgerCare Plus and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by Tuberculosis-Related Medicaid and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF files, which can be viewed with Adobe Reader computer software. Providers may also complete and print fillable PDF files using Adobe Reader.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the Tab key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader at no charge from the Adobe website. Adobe Reader only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat is purchased, providers may save completed PDFs to their computer. Refer to the Adobe website for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft Word format on the Portal. The fillable Microsoft Word format allows providers to complete and print the form using Microsoft Word. To complete a fillable Microsoft Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the Tab key to move from field to field.

Note: Providers may save fillable Microsoft Word documents to their computer by choosing Save As from the File menu, creating a file name, and selecting Save on their desktop.

Topic #766

Telephone or Mail Requests

Providers who do not have internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider

Services.

- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

    ForwardHealth
    Form Reorder
    313 Blettner Blvd
    Madison WI 53784

Portal

Topic #4743

Acute and Primary Managed Care Portal

Information and Functions Through the Portal

The acute and primary managed care area of the ForwardHealth Portal allows state-contracted HMOs to conduct business with ForwardHealth. The public HMO page offers easy access to key HMO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO (managed care organization) data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a From DOS (date of service) and a To DOS range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, phone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in pay status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once their PIN (personal identification number) is received. The administrative user is responsible for this provider account and can add accounts for other users (clerks) within their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields. Enter a backup user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks
- Add other organizations to the account
- Switch organizations

Refer to the Account User Guide on the User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (for example, licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- Your information was **updated** successfully. This message indicates that providers' files were immediately updated with the changed information.
- Your information was **uploaded** successfully. This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable)

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public **and** secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure)
- Trading Partners
- Members
- MCO (managed care organization)
- Partners

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

Inquiries to ForwardHealth via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the

relevant inquiry information, including selecting the preferred method of response (for example, telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, they may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the Provider link or button, then enter their username and password and click Go in the Login to Secure Site box at the right side of the screen.

If a user has forgotten their username, they can recover their username by choosing from the following options:

- Ask the Portal Helpdesk to do one of the following:
  - Send the Portal account username to the email account on record.
  - Verify the request with the designated account backup.
- Ask the Portal Helpdesk to remove the Portal account's current credentials and create a new account.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report
- Cost Share Report (long-term MCOs only)
- Enrollment Reports

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides payee MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click the Providers link or button.
3. Click the Request Portal Access link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click Search to display a listing of ForwardHealth

enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).

b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

   The financial payer is one of the following:
   - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.)
   - SSI (Supplemental Security Income)
   - WCDP (Wisconsin Chronic Disease Program)
   - WWWP (Wisconsin Well Woman Program)

c. Click **Submit**.
d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, HDAP (Wisconsin HIV Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in ForwardHealth Updates, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections, chapters, and topics. Sections within each handbook may include the following:

- Claims
- Coordination of Benefits
- Covered and Noncovered Services
- Managed Care
- Member Information
- Prior Authorization
- Provider Enrollment and Ongoing Responsibilities
- Reimbursement
- Resources

Each section consists of separate chapters (for example, claims submission, procedure codes), which contain further detailed information in individual topics.

Search Function

The Online Handbook has a search function that allows providers to search for a specific word, phrase, or topic number within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the search function by following these steps:

1. Go to the Portal.

2. Click **Online Handbooks** under the Policy and Communication heading.
3. Complete the two drop-down selections at the left to narrow the search by program and service area, if applicable. This is not needed if searching the entire Online Handbook.
4. Enter the word, phrase, or topic number you would like to search.
5. Select **Search within the options selected above** or **Search all handbooks, programs and service areas; or Search by Topic Number.**
6. Click **Search**.

Saving Preferences

Providers can select Save Preferences when performing a search (by service area, section, chapter, topic number) and will receive confirmation that their preferences have been saved. This will save the program (for example, BadgerCare Plus and Medicaid) and service area (for example, Anesthesiologist) combinations that are selected from the drop-down menus. The next time the provider accesses the Online Handbook, they will be taken to their default preferences page. The provider can also click the Preferences Home link, which returns the provider to the saved area of the Online Handbook with their default preferences.

ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view previous versions of the Online Handbook. Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

Add Backup Contact Information for Provider Administrator Accounts

Provider administrators must set up a backup contact for their Portal accounts to ensure that requests and changes can be verified as legitimate. Provider administrators will not be able to use the same contact information for both the administrator account and the backup contact.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage, or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (for example, claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (for example, different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the switch org function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (for example, they may do member enrollment verification for one Portal account and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

Interactive Maximum Allowable Fee Schedule

Within the Portal, are maximum allowable fee schedules for most services. Providers can search the interactive maximum allowable fee schedule by a single procedure code, multiple codes, a code range, or by a service area to find the maximum allowable fee. Through the interactive fee schedule, providers also can export their search results for a single code, multiple codes, a code range, or by service area. The downloadable fee schedules, which are updated monthly, are downloadable only by service area as TXT (text) or CSV (comma separated value) files.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare & Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the ForwardHealth Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Trainings

Providers can register for all scheduled trainings and view online trainings via the Trainings page, which contains an up-to-date calendar of all available training. Additionally, providers can view webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (for example, a phone call or email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the

application.

Other Resources Available on the Portal

The public Provider area of the Portal also includes the following features:

- A What's New? section for providers that links to the latest information posted to the Provider area of the Portal.
- Home page for the provider. (Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.)
- Email subscription service for Updates. (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in pay status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting PA and Amendment Requests via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- Save a partially completed PA request and finish completing it at a later time. (Note: providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a two-way message center where providers can send and receive electronic notifications as well as receive links to ForwardHealth provider publications. Providers will be able to send secure messages to select Wisconsin DHS (Department of Health Services) groups/staff by selecting a recipient from a drop-down menu; options in the drop-down menu will differ based on the provider's security role. All new messages will be displayed on the provider's secure Portal messages inbox.

Providers can sign up to receive notifications about the availability of new ForwardHealth messages through email, text, or both. After signing up, the user will receive a verification email to register their device. Once registered, providers will receive notifications by the requested method(s).

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information; providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4905

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA (prior authorization) requests via the ForwardHealth Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PAs and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Safari v. 14 or higher, Firefox v. 38 or higher
Mac OS X 10.2 or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission
- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the Default Provider ID on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (for example, hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an email address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth email subscription service.

To sign up for a secure Portal account, click the Request Portal Access link in the Quick Links box on the Provider page of the Portal. To sign up for email subscription, click Register for Email Subscription in the Quick Links box on the Provider page of the Portal.

Updates

Topic #478

Accessing ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the ForwardHealth Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging using both email subscription and secure Portal messaging to notify providers of newly released ForwardHealth Updates. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information.

Secure Portal Messages

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

Email Subscription Messages

Providers and other interested parties may register to receive email subscription notifications. When registering for email subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, HDAP (Wisconsin HIV Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (for example, physician, hospital, DME (durable medical equipment) vendor), and/or specific area of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an email subscription and may select multiple subscription options.

Registering for Email Subscription

Users may sign up for an email subscription by following these steps:

1. Click the Register for Email Subscription link on the ForwardHealth Portal home page.
2. The Subscriptions page will be displayed. In the Email field in the New Subscriber section, enter the email address to which messages should be sent.
3. Enter the email address again in the Confirm Email field.

4. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
5. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
6. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
7. When service area selection is complete, click Save at the bottom of the page.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without internet access may call Provider Services to request that a paper copy of a ForwardHealth Update be mailed to them. To expedite the call, correspondents will ask providers for the Update number. Providers should allow seven to 10 business days for delivery.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with phones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers, that exists on the DOS or within the DOS range selected will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health insurance coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options to:
  - Hear the information again.
  - Request enrollment information for the same member using a different financial payer.
  - Hear another member's enrollment information using the same financial payer.
  - Hear another member's enrollment information using a different financial payer.
  - Return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is **not** enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (for example, press *21 to enter an A, press *72 to enter an R).

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press # for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status
- Enrollment verification
- PA (prior authorization) status
- Provider CheckWrite information

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable financial payer program, (for example, Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the From DOS and the To DOS for the inquiry. The From DOS is the earliest date the provider requires enrollment information and the To DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

PA Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (for example, NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code). When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

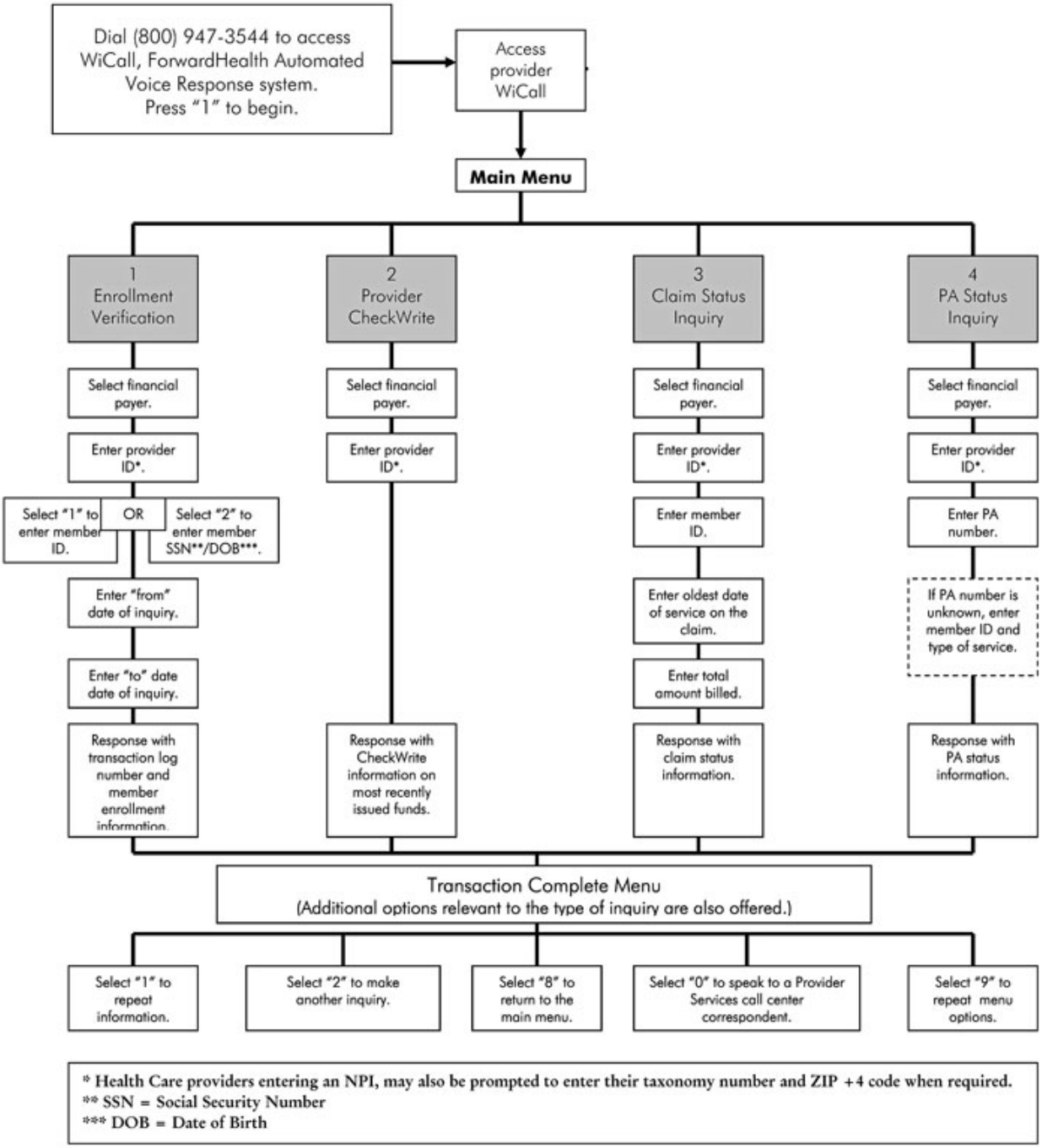
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth