Wisconsin
Department of Health Services

Exhausting Other Health Insurance Sources Before Submitting Nursing Home Claims to ForwardHealth

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Wisconsin Medicaid and BadgerCare Plus are Payers of Last Resort

- Providers must make a reasonable effort to exhaust all existing other health insurance sources before submitting claims.
- ForwardHealth will begin systematically enforcing this requirement soon. An upcoming *Provider Update* will outline the dates.

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How can the facility find out about the member's liable third parties?

Access carrier and/or Medicare information using the ForwardHealth Portal, EVS, or by calling Provider Services. "Other" will display on the 270/271 transaction request.

- "Enrollment Verification" (Provider Online Handbook topic #5088) describes the information available when checking the Portal.
- "Enrollment Verification on the Portal" (Provider Online Handbook topic # 4901) describes the process to access information on the Portal.

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How can the facility find out about the member's liable third parties?

Check the Portal for the following supplemental information:

- ForwardHealth Trainings > Portal Fundamentals Webcast Training > Module 2: Enrollment Verification
- Provider > Portal User Guides > General Portal Functionality > Enrollment Verification

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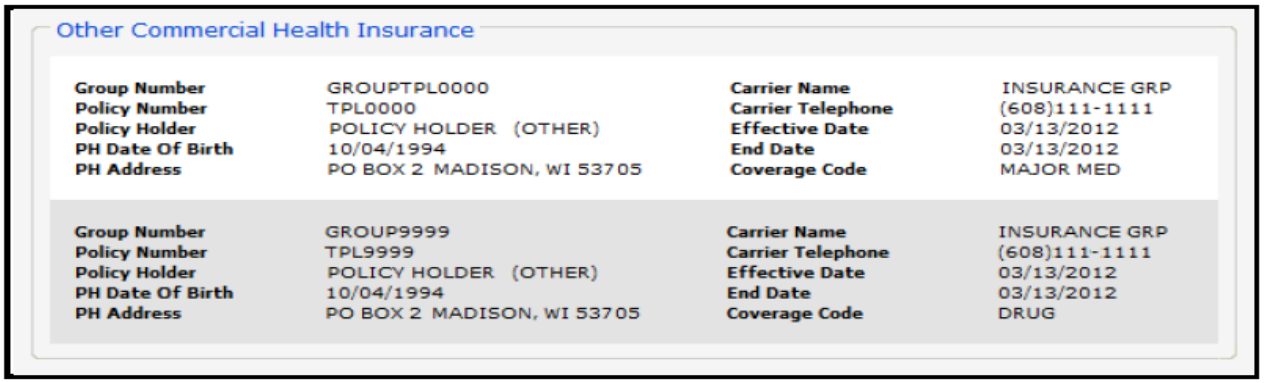
ForwardHealth Portal Enrollment Verification User Guide – Commercial Insurance Panel

2.2.9 Other Commercial Health Insurance Panel

The Other Commercial Health Insurance panel displays any other commercial health insurance coverage applicable members have for the DOS entered.



Other Commercial Health Insurance Panel

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ForwardHealth Portal Enrollment Verification User Guide – Medicare Panel

2.2.6 Medicare Panel

If the member has Medicare coverage, the Medicare panel will display the type of coverage and the start and end dates of the coverage.

Medicare

Coverage	Medicare Coverage Start Date	Medicare Coverage End Date
Medicare Part A	09/06/2011	09/06/2011
Medicare Part B	09/06/2011	09/06/2011
Medicare Part D	09/06/2011	09/06/2011

Medicare Panel

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What is considered a "reasonable effort"?

- Reference "Exhausting Commercial Health Insurance Sources" (Provider Online Handbook topic # 596) Step 4
  - Bill insurance carrier and wait 45 days for a response.
  - If no response, bill again and wait 30 days.
  - If no response, bill Medicaid with appropriate other insurance indicator.
- Reference "Exhausting Medicare Coverage" (Provider Online Handbook topic # 669)
  - Bill Medicare.
  - If no response via automatic crossover from Medicare within 30 days, bill Medicaid directly with the appropriate Medicare disclaimer code.

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What documentation is necessary to validate a "reasonable effort"?

- Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill commercial health insurance and/or Medicare.
- For the complete law, review DHS 106.02(9)
- In addition, the following topics reference when to utilize disclaimer information on claims:
  - "Other Insurance Indicators" (Provider Online Handbook topic #605)
  - "Medicare Disclaimer Codes" (Provider Online Handbook topic # 688)

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What type and duration of facility activity is impacted?

Commercial Insurance Carriers:

- Typical coverage of skilled nursing is for periods of time between 30 – 120 days.
- Commercial insurance carriers typically do not cover custodial care; thus, DHS would not expect providers to invoice commercial insurance carriers for custodial care.

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What type and duration of facility activity is impacted?

Medicare has rules regarding when they will cover skilled care.

- If a qualified hospital visit has been obtained prior to skilled care received in the nursing facility, DHS expects providers to invoice Medicare until Medicare no longer covers the member. This can be due to a lack in progress, or by maximizing the Medicare benefits per episode, including lifetime supply coverage days, if applicable.
- Custodial care is not covered by Medicare; thus, DHS would not expect providers to invoice Medicare for custodial care.

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What type and duration of facility activity is impacted?

Helpful information regarding commercial health insurance and/or Medicare billing, including Medicare Supplemental and Medicare Advantage plans can be found in the following topics:

- "Services Requiring Commercial Health Insurance Billing" (Provider Online Handbook topic #769) in the Commercial Health Insurance chapter of the Coordination of Benefits section.
- "Services Requiring Medicare Billing" (Provider Online Handbook topic #770) in the Medicare chapter of the Coordination of Benefits section.

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Helpful Provider Online Handbook Topics

(Requirements and Processes for Billing Other Health Insurance Sources)

- "Exhausting Commercial Health Insurance Sources" (topic #596)
- "Exhausting Medicare Coverage" (topic #669)
- "An Overview for Nursing Homes" (topic #3220)

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Claims Submission Resources

- For paper claims submission, refer to service area-specific claim submission completion instructions available in the Online Handbook.
- For electronic claims submission, refer to the HIPAA Version 5010 Companion Guides, available on the Trading Partner home page of the Portal.
- For direct data entry on the Portal, refer to the ForwardHealth Portal User Guides, available on the Provider home page of the Portal.

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Must the nursing facility wait for written feedback from the liable third party before submitting claims to ForwardHealth?

- Enter the cash adjustment reason code when submitting claims electronically.
- Supply the appropriate other insurance indicator or Medicare disclaimer code on the Explanation of Medical Benefits, F-01234 (11/14) form (Provider Online Handbook topic #18497) when submitting paper claims.
- Keep an audit trail.

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What is the policy for accepting members who are required to use a provider network?

Nursing facilities are required to refer members to providers affiliated with the member's commercial health insurance plan when their plan requires the use of a designated network of providers, and the member is also enrolled in BadgerCare Plus or Wisconsin Medicaid. (Provider Online Handbook topic # 601). Exceptions include:

- Services for which the nursing facility has obtained a referral from the liable third party.
- Emergency services.
- Medicaid covered services that are not covered under the commercial health insurance plan.

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What is the policy for accepting members who are required to use a provider network?

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 his or her commercial health insurance plan, the provider cannot collect payment from the member.

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What if the nursing facility finds a discrepancy in liable third party coverage?

Providers are encouraged to report commercial insurance and/or Medicare coverage discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report, F-01159(09/12) form.

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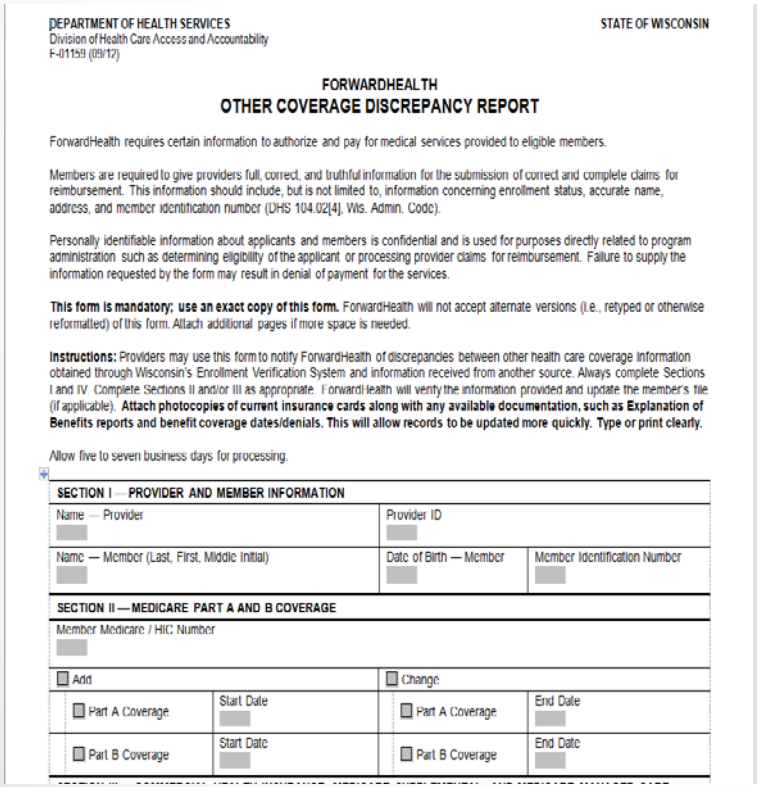
Other Coverage Discrepancy Report



DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01159 (09/12)

STATE OF WISCONSIN

FORWARDHEALTH
OTHER COVERAGE DISCREPANCY REPORT

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members.

Members 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 (DHS 104.02[4], Wis. Admin. Code).

Personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

This form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Attach additional pages if more space is needed.

Instructions: Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.**

Allow five to seven business days for processing.

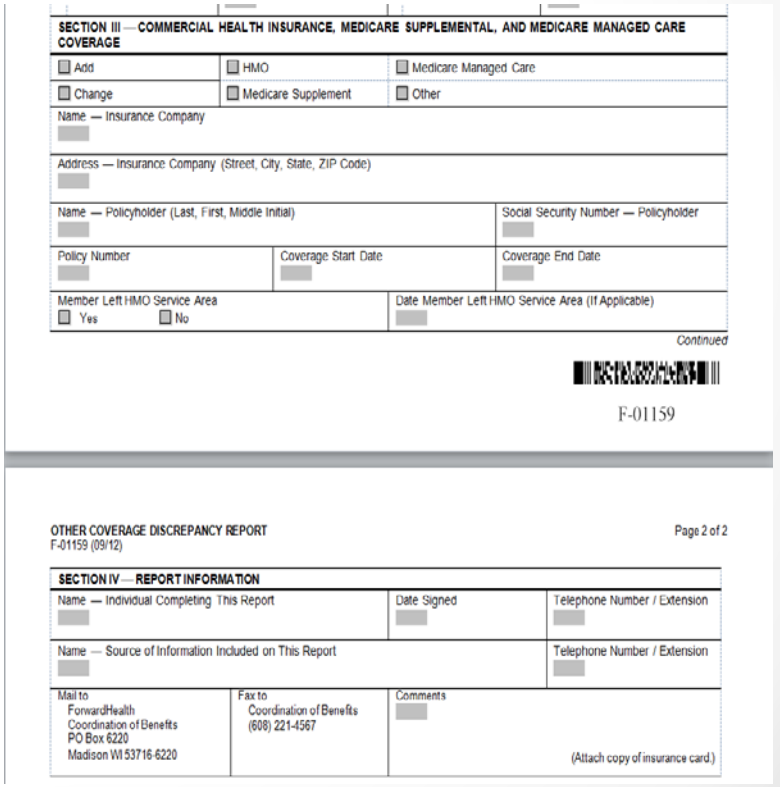
SECTION I — PROVIDER AND MEMBER INFORMATION

Name — Provider		Provider ID	
Name — Member (Last, First, Middle Initial)		Date of Birth — Member	Member Identification Number

SECTION II — MEDICARE PART A AND B COVERAGE

Member Medicare / HIC Number

☐ Add		☐ Change	
☐ Part A Coverage	Start Date	☐ Part A Coverage	End Date
☐ Part B Coverage	Start Date	☐ Part B Coverage	End Date



SECTION III — COMMERCIAL HEALTH INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

☐ Add	☐ HMO	☐ Medicare Managed Care
☐ Change	☐ Medicare Supplement	☐ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, ZIP Code)

Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date
Member Left HMO Service Area ☐ Yes ☐ No		Date Member Left HMO Service Area (If Applicable)

Continued

F-01159

OTHER COVERAGE DISCREPANCY REPORT
F-01159 (09/12)

Page 2 of 2

SECTION IV — REPORT INFORMATION

Name — Individual Completing This Report		Date Signed	Telephone Number / Extension
Name — Source of Information Included on This Report			Telephone Number / Extension
Mail to ForwardHealth Coordination of Benefits PO Box 6220 Madison WI 53716-6220	Fax to Coordination of Benefits (608) 221-4567	Comments	(Attach copy of insurance card.)

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Will providers be trained on the process?

- Providers will be notified via a *ForwardHealth Update*, banner messages, and EOB codes.
- Field representatives will contact each nursing facility to explain the information in the *Update* and to provide any additional detail when requested.
- No formal training will be necessary.

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Nursing Home claims submission during the "Education" time frame

- ForwardHealth will use its Remittance Advice when claim submission did not include information in regards to billing other health insurance.
- These claims will be identified by one, or both, of the following Explanation of Benefits (EOB) codes:
  - 1256: Member is enrolled in Medicare Part A on the Date(s) of Service.
  - 0278: Member is covered by a commercial health insurance on the Date(s) of Service.
- Providers will be reimbursed for claims(and adjustments) with the Remittance Advice notice during the Education time frame. The Education time frame will be identified in an upcoming *Update*.

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Nursing Home claims submission during the "Systematic Enforcement" time frame

- After the Education time frame completes, claims and adjustments processed for dates of service including those within the Education time frame submitted without the appropriate commercial health insurance and/or Medicare information will be denied with EOB codes 1256 or 0278.
- When a provider receives a claim denial with EOB code 1256 or 0278, the provider should bill all other health insurance sources for the member prior to resubmitting the claim.