wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Pharmacies
HMOs and Other Managed Care Programs

Wisconsin Medicaid extends deadline for resubmitting claims for retroactively eligible *Medicare* recipients

Effective October 2002, pharmacies will have 120 days, instead of the current 90 days, to submit to Wisconsin Medicaid the results of provider-based billing claims to *Medicare* for recipients diagnosed with end-stage renal disease (ESRD) and/or other related diagnoses who are retroactively eligible for *Medicare*.

Definition of provider-based billing

If a recipient becomes eligible for *Medicare* on a retroactive basis, the provider is required to submit certain Medicaid-paid claims to *Medicare* for reimbursement and follow Medicaid's policy regarding submission of crossover claims. The process Wisconsin Medicaid uses to facilitate this is called provider-based billing.

A provider-based billing claim is a completed claim form that Wisconsin Medicaid sends to providers for services Wisconsin Medicaid has already reimbursed. Providers may use this claim to submit to the primary payer (in this case, *Medicare*) or they may generate their own claim. If *Medicare* requires additional information for processing beyond what is on the provider-based billing claim, the provider must include that information on the claim they submit to *Medicare*.

Submitting provider-based billing claims

Effective October 2002, pharmacies will have 120 days, instead of the current 90 days, to submit to Wisconsin Medicaid the results of provider-based billing claims to *Medicare* for recipients diagnosed with end-stage renal disease and/or other related diagnoses who are retroactively eligible for *Medicare*. Providers will receive the following from Wisconsin Medicaid to submit provider-based billing claims:

1. *Medicare Part B Provider-Based Billing notification letter.* This includes instructions on how to submit provider-based billing claims. Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a sample notification letter.
2. *Provider-Based Billing Summary.* This lists the claims to be submitted to *Medicare*. It includes each Medicaid claim for which a provider-based billing claim form was generated and a Medicaid internal control number for each claim. Refer to Attachment 2 for a sample Provider-Based Billing Summary.
3. *Provider-based billing claims.* Providers will receive copies of the provider-based billing claims to submit to *Medicare*.

Pharmacies are required to send a copy of the Provider-Based Billing Summary, along with supporting documentation showing that *Medicare* processed the claim, to Wisconsin Medicaid within 120 days from the date on the notification letter. By doing so, providers will avoid future payment deferral by Wisconsin Medicaid.

After 120 days of receiving the summary

If Wisconsin Medicaid does not receive a response within 120 days of the date of the Provider-Based Billing Summary, Wisconsin Medicaid will defer from future provider payments the amount equal to the original Medicaid payment.

Payment deferral is not a final action. Wisconsin Medicaid will accept documentation of *Medicare's* payment, denial, or non-action after 120 days have elapsed; therefore, it is not necessary to request a hearing.

More information

For more information on *Medicare* retroactive eligibility and provider-based billing, refer to the Coordination of Benefits section of the All-Provider Handbook or call Provider Services at (800) 947-9627 or (608) 221-9883.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

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

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

ATTACHMENT 1
Sample Medicare Part B Provider-Based Billing notification

(A copy of the sample Medicare Part B Provider-Based Billing notification is located on the following pages.)

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DIVISION OF HEALTH CARE FINANCING

COORDINATION OF BENEFITS UNIT
P O BOX 6220
MADISON WI 53716

Telephone: 608-221-4746
FAX: 608-221-4567

www.dhfs.state.wi.us

Scott McCallum
Governor

Phyllis J. Dubé
Secretary

State of Wisconsin

Department of Health and Family Services

MEDICARE PART B
PROVIDER-BASED BILLING
IMPORTANT (Response required within 120 days)

If a recipient becomes eligible for Medicare on a retroactive basis, the provider is required to submit certain Medicaid-paid claims to Medicare for reimbursement and follow Medicaid's policy regarding submission of crossover claims. The process Wisconsin Medicaid uses to facilitate this is called provider-based billing.

Wisconsin Medicaid has been informed that the recipient(s) identified on the enclosed Provider-Based Billing Summary and claim(s) have Medicare coverage for the dates of service listed. This information was received after Wisconsin Medicaid paid this claim(s).

Since benefits under Wisconsin Medicaid are secondary to those provided by Medicare, providers are required to seek reimbursement from Medicare per HFS 106.03(6) AND (7) Wis. Admin. Code. Providers may not bill recipients for these services.

Return all responses from Medicare within 120 days of the date of the attached summary and include the required supporting documentation (described below) and a copy of the Provider-Based Billing Summary to the following address:

Wisconsin Medicaid
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220

Providers also have the option of faxing the required information to **Medicaid Provider-Based Billing** at **(608) 221-4567**.

If no response is received by Wisconsin Medicaid within 120 days, future payments will be deferred in the amount equivalent to the original Medicaid payment amount for the attached claims. The payment deferral is not considered a final action. Wisconsin Medicaid will accept documentation of Medicare's payment, denial, or non-action after 120 days have elapsed. Therefore, it is not necessary to request a hearing. Refer to the instructions under Section C of this letter for rebilling after a payment deferral has occurred.

SECTION A — SUBMITTING CLAIMS

1. All Providers

Submit the enclosed claims (or providers may produce their own) to Medicare Part B. Ensure that the correct Medicare provider number, Universal Provider Identification Number (UPIN), and Health Insurance Claim (HIC) number (nine digits followed by a one- or two-digit alphanumeric code) are on the claims. Attach any additional documentation required by Medicare.

Note: Providers are required to seek Medicare payment for all dual entitlees (eligible for Medicare and Wisconsin Medicaid) to whom they provide Medicare-covered services. Medicare may retroactively enroll physicians who had valid Wisconsin licenses on the claim date of service.

2. Pharmacies
The National Council for Prescription Drug Programs (NCPDP) electronic claim format only contains one “Other Insurance Indicator” field. If a recipient has both commercial health insurance and Medicare, Wisconsin Medicaid requires that providers reflect the results of billing the commercial carrier in the "other insurance indicator" field. Therefore, if there is both Medicare and commercial drug coverage, it is not apparent to Wisconsin Medicaid whether Medicare was billed.

Provider-based bills are created based on the assumption that Medicare was not previously billed. If Medicare was billed, do not re-bill Medicare. In this case, it is sufficient to provide either a copy or fax of the Medicare Remittance Advice and the Provider-Based Billing Summary page to the applicable address above. If Medicare was not previously billed, bill Medicare, then proceed according to Sections B and C of this letter.

SECTION B — RESPONSES WITHIN 120 DAYS

1. Medicare Payment
When Medicare approves payment, the claim should automatically crossover to Wisconsin Medicaid. The original Medicaid payment should be refunded in full to Wisconsin Medicaid along with a copy of the Medicare Remittance Notice (MRN) and the Provider-Based Billing Summary page. Send this information to the address listed on the previous page.

- Wisconsin Medicaid will create an adjustment to apply the full or partial payment. Do not submit an Adjustment Request form.
- Providers also have the option of sending a refund check along with a copy of the MRN and the Provider-Based Billing Summary page to the address listed on the previous page.

2. Medicare Denial
If Medicare denies payment, send a copy of the MRN and the Provider-Based Billing Summary to the address above.

SECTION C — RESPONSES AFTER 120 DAYS

1. Date of Service within 12 months
Providers should submit a new Medicaid claim through normal processing channels if the date of service is within 12 months and a payment or denial is received from Medicare. Do not use the provider-based billing claim created by Wisconsin Medicaid. Apply the appropriate Medicare disclaimer code. For correct use of Medicare Disclaimer Codes, refer to the Coordination of Benefits section of the Wisconsin Medicaid All-Provider Handbook. (Pharmacies should refer to NCPDP billing guidelines.)

2. Date of Service greater than 12 months
If the date of service is more than 12 months and a payment or denial is received from Medicare, providers may submit a Medicaid claim to the following address:

Wisconsin Medicaid
GR Retro-Eligibility
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Do not use the provider-based billing claim created by Wisconsin Medicaid. Apply the appropriate Medicare disclaimer code. For correct use of Medicare Disclaimer Codes, refer to the Coordination of Benefits section of the Wisconsin Medicaid All-Provider Handbook. (Pharmacies should refer to NCPDP billing guidelines.) In addition, please include documentation of payment or denial (as indicated in Section B, parts 1 and 2 of this letter) and the Provider-Based Billing Summary.

If you have any questions, contact Medicaid Coordination of Benefits at (608) 221-4746, ext. 3142.

ATTACHMENT 2
Sample Provider-Based Billing Summary

(A copy of the sample Provider-Based Billing Summary is located on the following page.)

PROVIDER BASED BILLING SUMMARY PAGE 1

BILLING PROVIDER NUMBER: 12345678 CURRENT DATE: 12/08/01

CARRIER CODE: 999 CARRIER NAME: MEDICARE PART B

CLAIM ICN	RECIPIENT MEDICAL ASSISTANCE NUMBER	RECIPIENT LAST AND FIRST NAME		CLAIM FROM DATE OF SERVICE	FINAL STATUS OF CLAIM	AMOUNT PAID ON CLAIM
123456789012345	1234567890	RECIPIENT	IMA1	06/04/01	_____	_____
123456789012344	1234567890	RECIPIENT	IMA1	12/30/99	_____	_____
123456789012346	1234567891	RECIPIENT	IMA2	01/01/01	_____	_____
123456789012347	1234567892	RECIPIENT	IMA3	01/01/01	_____	_____
123456789012348	12345678[illegible]2	RECIPIENT	IMA3	01/01/01	_____	_____
123456789012349	123[illegible]67893	RECIPIENT	IMA4	01/01/01	_____	_____
123456789012341	1234567894	RECIPIENT	IMA5	01/01/01	_____	_____
12345678901234	1234567894	RECIPIENT	IMA5	01/01/01	_____	_____
123456789012343	1234567895	RECIPIENT	IMA6	01/01/01	_____	_____
123456789012331	1234567895	RECIPIENT	IMA6	01/01/01	_____	_____
123456789012332	1234567895	RECIPIENT	IMA6	01/01/01	_____	_____

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