wisconsin Medicaid update
and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
All Providers
HMOs and Other Managed Care Programs

Changes to billing and reimbursement for services provided to dual entitlees as a result of HIPAA and the Wisconsin biennial budget

This *Wisconsin Medicaid and BadgerCare Update* describes billing and reimbursement changes for dual entitlees as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Wisconsin biennial budget (2003 Wisconsin Act 33).

Dual entitlees
Some recipients are eligible for coverage by both Wisconsin Medicaid and Medicare, either Medicare Part A, Part B, or both. Wisconsin Medicaid classifies these recipients as dual entitlees.

Medicare crossover claim
A Medicare crossover claim is a Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for payment of coinsurance, deductible, and copayment.

Changes to billing for Medicare crossover claims for dual entitlees as a result of HIPAA

Changes to billing for Medicare crossover claims for dual entitlees as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) are as follows:

- To ensure proper reimbursement when submitting electronic claim instructions to Medicare for dual entitlees, the provider is required to include his or her Medicaid provider number in the billing provider secondary identification segment on the 837 Health Care Claim: Institutional (837I) or Professional (837P) electronic transaction. The provider is also required to complete the other subscriber information loop on the 837I or 837P electronic transaction by including the following:
  - ✓ The recipient's Medicaid identification number.
  - ✓ The provider's Medicaid rendering provider number, when applicable.

  If the provider does not include the previously listed information, any of the following could result:
  - ✓ The claim may not automatically cross over.
  - ✓ The claim may be denied.
  - ✓ The reimbursement amount may be incorrect.
  - ✓ The wrong provider may be reimbursed.
- Providers should send crossover claims from the Medicare Plus Choice Plan (Medicare HMO) to Wisconsin Medicaid as Wisconsin Medicaid will now pay the copayments for these claims.

Billing changes for outpatient hospital crossover claims

Claims submitted electronically

For outpatient hospital crossover claims, dates submitted as a range will be split and will appear as individual dates on the Remittance and Status Report.

Wisconsin Medicaid will process up to 28 detail lines per claim for HIPAA-compliant electronic claims received on and after October 13, 2003. Claims submitted with more than 28 detail lines will be split into multiple claims. Refer to the August 2003 *Wisconsin Medicaid and*

BadgerCare Update (2003-134), titled "Wisconsin Medicaid will split claims and claim details in certain situations," for more information on detail line limits.

Claims submitted on paper

When series billing (i.e., billing from two to four dates of service [DOS] on the same line) on the UB-92 (CMS 1450) claim form, indicate the DOS in Form Locator 43 or Form Locator 45 in the following format: MM/DD/YY MM/DD MM/DD MM/DD. Indicate the dates in ascending order. Providers may enter up to four DOS for each revenue and procedure code if all the following conditions are met:

- All DOS are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four DOS per revenue code, indicate the dates on the subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim including the "Total Charges" line.

These billing instructions are in accordance with National Uniform Billing Committee (NUBC) UB-92 Billing Manual guidelines. Claims may be denied if they do not meet the specified guidelines.

For more information, go to the NUBC Web site at *www.nubc.org/*.

Processing automatic crossover claims

Wisconsin Medicaid will continue to receive and process automatic crossover claims from the following Medicare intermediaries and carriers when dual-entitlee status is identified:

- *AdminaStar Federal, Inc.* Medicare durable medical equipment regional carrier.
- *Blue Cross and Blue Shield of Florida (First Coast Service Options, Inc.)*. Medicare Part A fiscal intermediary.
- *Blue Cross and Blue Shield United of Wisconsin (United Government Services)*. Medicare Part A fiscal intermediary.
- *Blue Cross and Blue Shield of Tennessee (Riverbend)*. Medicare Rural Health Clinics carrier.
- *Trailblazer Health Enterprises, LLC*. Medicare Indian Health Services Part A fiscal intermediary.
- *Wisconsin Physician's Service Insurance Corporation (WPS)*. Medicare Part B carrier.

If Medicare supplemental health insurance is indicated on the Medicare claim, Medicare will automatically forward the claim to the supplemental insurance, not to Wisconsin Medicaid.

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The following types of claims will not be automatically forwarded to Wisconsin Medicaid:

- Medicare supplemental health insurance claims.
- Claims using the National Council for Prescription Drug Programs (NCPDP) standard.
- Medicare HMO claims.

Providers should submit Medicare HMO claims to Wisconsin Medicaid *immediately* after receiving Medicare payment notification. For all other types of claims, providers should continue to wait 30 days to see if the claim crossed over automatically before submitting an electronic or paper crossover claim to Wisconsin Medicaid.

Provider-submitted crossover claims for outpatient hospital services

Wisconsin Medicaid will continue to accept the pre-HIPAA formats for Medicare crossover claims for outpatient hospital services. A future *Update* will provide additional information.

Medicare Plus Choice Plan copayment

For outpatient crossover claims received on and after October 13, 2003, Wisconsin Medicaid pays the Medicare Plus Choice Plan (Medicare HMO) copayment, as well as the Medicare deductible, in full.

Changes to Medicaid reimbursement for outpatient hospitals as a result of the Wisconsin biennial budget

As a result of the Wisconsin biennial budget (2003 Wisconsin Act 33), for DOS on or after October 1, 2003, Wisconsin Medicaid reimbursement methodology for Medicare coinsurance on outpatient hospital claims is the lesser of the following:

- The Medicare coinsurance amount.
- The Wisconsin Medicaid payment rate for the outpatient claim less the Medicare payment.

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 HIPAA-related changes, 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/*.

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