wisconsin Medicaid update and BadgerCare

June 2003 ● No. 2003-38
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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Hospice Providers

HMOs and Other Managed Care Programs

Changes to local codes and paper claims for hospice services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for hospice services, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 (CMS 1450) paper claim instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

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/*.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for hospice services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., documentation requirements), but include:

- Adopting nationally recognized revenue codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 (CMS 1450) paper claim form instructions.

Note: Use of the newly adopted national codes and revised paper claim instructions prior to implementation dates may result in claim denials.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for hospice services.

Nationally recognized revenue codes

Wisconsin Medicaid will adopt nationally recognized four-digit revenue codes to replace currently used three-digit local codes for hospice services. Providers will be required to add a preceding "0" to the current three-digit revenue codes when submitting claims for hospice services. Revenue code descriptions for hospice services are not changing. Refer to Attachment 1 of this *Update* for a list of newly adopted revenue codes. Providers must use the appropriate revenue code that describes the service performed.

Value codes

Local value code "22" (Surplus) is no longer used to indicate spenddown. Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

With the implementation of HIPAA, providers billing for patient liability must not use local value code "84" on claims or adjustments. Wisconsin Medicaid is changing the way hospice providers indicate patient liability on all claims and adjustments. Hospice providers have already been notified of this change through the June 2003 *Update* (2003-32), titled "Changes to patient liability billing due to HIPAA."

Coverage for hospice services

Medicaid coverage and documentation requirements for hospice services remain unchanged. Refer to the Hospice Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of UB-92 paper claim instructions

With the implementation of HIPAA, Medicaid-certified hospice providers will be required to follow the revised instructions for the UB-92 paper claim form in this *Update*, even though the actual UB-92 claim form is not being revised at this time. Refer to Attachment 2 for the revised instructions. Attachment 3 is a sample claim for hospice services that reflects the changes to the billing instructions.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the UB-92 claim form instructions

Revisions to the UB-92 paper claim form instructions include the following:

- Local value code "22" should no longer be used to indicate spenddown. Also, providers billing for patient liability must not use local value code "84" (Form Locators 39-41 a-d).
- Revenue codes revised (Form Locator 42).
- Payer revised. If applicable, enter "patient liability amount" to identify any patient liability. (Form Locator 50 A-C).
- Prior payments revised (Form Locator 54 A-C and P).
- Estimated amount due revised. If applicable, enter the dollar amount of any patient liability. (Form Locator 55 A-C and P).
- Medicare and other insurance disclaimer codes revised (Form Locator 84 a-d).

Medicaid coverage and documentation requirements for hospice services remain unchanged.

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

ATTACHMENT 1
Hospice services revenue code chart

Wisconsin Medicaid will adopt nationally recognized four-digit revenue codes to replace currently used three-digit local codes for hospice services. Providers will be required to add a preceding "0" to the current three-digit revenue codes when submitting claims for hospice services. Revenue code descriptions for hospice services are not changing. The national revenue codes are listed below.

National revenue code	Description
0169	Room and board — Other (for skilled nursing facility/intermediate care facility)
0651	Hospice services — Routine home care (up to 7.5 hours)
0652	Hospice services — Continuous home care (8-24 hours)
0655	Hospice services — Inpatient respite care
0656	Hospice services — General inpatient care

ATTACHMENT 2
UB-92 (CMS 1450) claim form instructions for hospice services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the Form Locator descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required form locators as appropriate. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

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

Wisconsin Medicaid recipients receive a Medicaid identification card when initially determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. Minimum requirement is the provider's name, city, state, and Zip code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — ERO Assigned Number (not required)

Form Locator 3 — Patient Control No. (not required)

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. The first digit identifies the type of facility. The second digit classifies the type of care. Hospice providers should use bill types 81X (non-hospital-based hospice) and 82X (hospital-based hospice). The third digit ("X") indicates the billing frequency and providers should enter one of the following for "X":

1 = Admit through discharge claim
2 = Interim — first claim
3 = Interim — continuing claim
4 = Interim — final claim

Form Locator 5 — Fed. Tax No. (not required)

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

Form Locator 7 — Cov D. (not required)

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (not required)

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src (not required)

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

Form Locator 23 — Medical Record No.

This is an optional field. Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locators 24-30 — Condition Codes (required, if applicable)

If appropriate, enter a code to identify conditions relating to this claim.

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — 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. Enter dates in MM/DD/YY format (e.g., January 1, 2004, would be 010104).

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

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

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

Form Locators 39-41 a-d — Value Code and Amount (required, if applicable)

Wisconsin Medicaid uses the following value codes:

Code	Description
81	*Medicare Part B Charges When Part A Exhausted*. Enter the full amount of Medicare Part B charges when billing for services after Medicare Part A has been exhausted.
83	*Medicare Part A Charges When Part A Exhausted*. Enter the sum of the Medicare paid amount, the coinsurance amount, and the deductible when billing for services after Medicare Part A has been exhausted.

Form Locator 42 — Rev. Cd.

Enter the national four-digit revenue code which identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code "0001" on the line with the sum of all the charges.

Form Locator 43 — Description

Enter the date of service (DOS) in MM/DD/YY format in Form Locator 43 or Form Locator 45.

When series billing (i.e., billing from two to four DOS on the same line), indicate the DOS 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 code if:

- 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.

Form Locator 44 — HCPCS/Rates (not required)

Form Locator 45 — Serv. Date

Enter the DOS in MM/DD/YY format in Form Locator 45 or Form Locator 43. Multiple DOS must be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of covered accommodations days, ancillary units of service, or visits, where appropriate. Units are measured in days for revenue codes "0169," "0651," "0655," and "0656," and in hours for revenue code "0652."

Form Locator 47 — Total Charges

Enter the usual and customary charge for each line item. Enter revenue code "0001" to report the sum of all charges in Form Locator 47.

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

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer

Enter all health insurance payers here. For example, enter "T19" for Wisconsin Medicaid and/or the name of private insurance. Enter "patient liability amount" to identify any patient liability.

Form Locator 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Form Locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

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

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

Form Locator 54 A-C & P — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 84.) If the commercial insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due (required, if applicable)

Enter the dollar amount of any patient liability.

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured's Name (not required)

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

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.

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 — ESC (not required)

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

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.

Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (up to five digits) code describing the principal diagnosis (e.g., 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 "E" codes.

Form Locators 68-75 — Other Diag. Codes

Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 76 — Adm. Diag. Cd. (not required)

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Form Locator 80 — Principal Procedure Code and Date (not required)

Form Locator 81 — Other Procedure Code and Date (not required)

Form Locator 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number or license number and name.

Form Locator 83 a-b — Other Phys. ID (not required)

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial health insurance billing information

Commercial health insurance coverage must be billed prior to billing Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the recipient has dental ("DEN") or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial insurance, ***and*** the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes ***must*** be indicated in Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient'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 recipient 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 Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Medicare information

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

If none of the previous Medicare information is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
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 recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient 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 the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient 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 the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

ATTACHMENT 3
Sample UB-92 claim for hospice services

APPROVED OMB NO. 0938-0279

IM BILLING HOSPICE 321 HOSPICE RD ANYTOWN, WI 55555 (555) 321-1234	2			3 PATIENT CONTROL NO.					4 TYPE OF BILL 811	
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11		

12 PATIENT NAME: RECIPIENT, IMA H.

13 PATIENT ADDRESS:

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	26	28	30	31

	32 OCCURRENCE CODE	DATE	33	34 OCCURRENCE CODE	DATE	35	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a										A
b										B
										C

38

	39 VALUE CODES CODE	AMOUNT	40	41 VALUE CODES CODE	AMOUNT
a					
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0169	020104 0202 0203 0204			4.0	XXX XX		
2		0205 0206 0207 0208			4.0	XXX XX		
3		0209 0210 0211 0212			4.0	XXX XX		
4		0213 0214 0215 0216			4.0	XXX XX		
5		0217 0218 0219 0220			4.0	XXX XX		
6		0221 0222 0223 0224			4.0	XXX XX		
7								
8	0651	022504 0226 0227 0228			4.0	XXX XX		
9		0229			1.0	XX XX		
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	TOTAL CHARGES				XXXX XX		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	45009 BLUE CROSS	BC111			XXXX XX		
B	T19 MEDICAID	87654321					
C	PATIENT LIABILITY					XX XX	
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			1234567890		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
0420	486		7070		4280						

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	N24680 I.M. Physician

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

OTHER PHYS. ID

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b	OI-P		
c		X *Ima H. Provider*	030104
d			

UB-92 HCFA-1450 **OCR / Original**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.