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

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 and SeniorCare participants 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 to the Wisconsin Medicaid paper Remittance and Status Report

Wisconsin Medicaid will revise the paper Remittance and Status (R/S) Report as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These revisions are highlighted in this *Wisconsin Medicaid and BadgerCare Update.*

Paper Remittance and Status Report revised

The Wisconsin Medicaid paper Remittance and Status (R/S) Report will be revised as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Revisions to the paper R/S Report will first appear on R/S Reports dated October 17, 2003, and will include the following:

- The Accounting Number field will be renamed Patient Control Number and expanded to 20 characters.
- Wisconsin Medicaid will accept a 30-character Medical Record Number field on paper and electronic claims, but the R/S Report will display only the first 18 characters.
- The type of service field will be removed.
- Two additional modifier fields will be added.
- A report of the status of prior authorizations (PAs) will be discontinued. The Wisconsin Medicaid PA department will continue to send providers a copy of the Prior Authorization Request Form (PA/RF).
- The monthly list of claims pending more than 30 days will be discontinued.

Wisconsin Medicaid will continue to use current Explanation of Benefits and Diagnosis-Related Group codes on the R/S Report.

Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for instructions on how to interpret the revised R/S Report. Attachment 2 is an example of the revised R/S Report. Refer to Attachment 3 for instructions on how to interpret an adjustment on the R/S Report. Attachment 4 is an example of an R/S Report displaying an adjusted claim.

Refer to the Claims Submission section of the All-Provider Handbook for additional information regarding how to use the R/S Report to verify accuracy of claim information, how to verify the check amount sent with the R/S Report, and requirements for maintaining R/S Reports.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information 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.

ATTACHMENT 1

Reading the paper Medicaid Remittance and Status Report

The Medicaid Remittance and Status Report (R/S) is sent each week to providers that had at least one claim finalized. The R/S Report is the best tool for interpreting Medicaid claim payments and denials to determine what follow-up action may be needed by the provider.

The following item-by-item description explains the basic information that always appears on the R/S Report. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a sample R/S Report with key items highlighted.

Note: Financial items and identifying information may also appear on the report to acknowledge special transactions such as voluntary refunds by the provider or any Medicaid check that is outstanding beyond 90 days. Pharmacy Point-of-Sale real-time denied claims are not included on the R/S Report for Wisconsin Medicaid and SeniorCare.

Banner Page

Wisconsin Medicaid advises providers to read the banner page for important time-sensitive information that may apply to all providers or to specific provider groups. The page may include information on Medicaid-initiated adjustments, claims submission deadlines, and upcoming seminars. Providers should also maintain the banner page with the entire R/S Report. Providers can also view the banner page by accessing the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Header Information

1H. Provider Name and Address

Indicates the name and address of the billing provider's payee as indicated on the Wisconsin Medicaid file. The payee's name and address is used for tax purposes on the 1099. (This is not necessarily the name of the billing provider.)

2H. R/S Number

Indicates the R/S Report number.

3H. Provider Number

Indicates the billing provider's eight-digit Medicaid provider number from the claim or adjustment.

4H. Date

Indicates the date the R/S Report and check were printed.

5H. Page

Indicates the page number for this R/S Report. Paid/denied claim information generally starts on page 2.

6H. Report Number

Indicates the number of R/S Reports the provider has received in the current calendar year.

Paid or Denied Claim Adjustment Information

Review and verify the accuracy of individual claim information and determine appropriate follow-up action — these are key items that could affect payment or denial.

1A. Patient Name

Indicates the recipient's last name and first name (or first initial). The recipient's most current name on the Medicaid eligibility file will always appear on the R/S Report. If the recipient has changed names, the name on the R/S Report will not necessarily be the name on the claim submitted by the provider.

2A. Patient Identification No.

Indicates the recipient's ten-digit Medicaid identification number.

3A. Medical Record No.

Indicates the first 18 characters of the recipient's medical record number as recorded on the Medicaid claim or adjustment request.

4A. Patient Control Number

Indicates the recipient's account number as recorded on the Medicaid claim.

5A. Claim Number

Indicates the unique 15-digit number assigned by Wisconsin Medicaid to the claim or adjustment. Refer to the Claims Submission section of the All-Provider Handbook for an explanation of the claim number. The region "98" no longer applies.

6A. Service Dates

Indicates the dates of service (or date range) corresponding to when the service(s) was provided.

7A. UD (when applicable)

Gives the unit dose indicator as recorded on the Medicaid drug claim.

8A. NS (when applicable)

Gives the no substitute indicator as recorded on the Medicaid drug claim.

9A. Perf Prov/Rx Number (when applicable)

Indicates the performing provider number of the provider who performed the service or the prescription number.

10A. Days/Qty

Indicates the number of units, services, accommodation days, or supply quantity billed.

11A. Proc/Accom/Drug Cde/M1 M2 M3 M4

Provides the procedure code for the service(s) provided. Modifiers may also be indicated following the code.

12A. Procedure/Accommodation/Drug Description

Provides the procedure code description of the service(s) provided.

13A. Total Billed

Indicates the total billed charges for the service(s) shown on that line for claims or adjustments.

14A. Total Allowed

Indicates the Medicaid payment allowance (determined according to appropriate reimbursement criteria).

15A. Other Deducted Charges (when applicable)

Indicates the charges deducted from the total allowed for reasons such as other insurance payment or patient liability (hospice and nursing home claims).

16A. Copay (when applicable)

Indicates the recipient Medicaid copayment amount deducted from total allowed amount.

17A. Paid Amount

Indicates the actual amount paid by Wisconsin Medicaid.

18A. EOB Codes

Indicates the numeric Medicaid proprietary Explanation of Benefits (EOB) code that corresponds to a printed message about the disposition of the claim or adjustment. (A list of the EOB codes used, with their narrative description, appears on the last page of the R/S Report.)

1R. Reminder

Wisconsin Medicaid checks cannot be cashed after 180 days.

Payment Summary Information

1P. Claims Payment Summary

Indicates the amount of the actual Medicaid payment made in this week's check.

2P. Claims Paid

a. Current Processed — Indicates the total number of claims processed on this R/S Report.
b. Year-to-Date Total — Indicates the total number of claims processed since the beginning of the calendar year.

3P. Claims Amount

a. Current Processed — Indicates the total dollar amount for the claims paid on this R/S Report.
b. Year-to-Date Total — Indicates the total actual claims payments since the beginning of the calendar year.

4P. Withheld Amount

a. Current Processed — Indicates the dollar amount of any withheld payments (e.g., negative adjustments) on this R/S Report.
b. Year-to-Date Total — Indicates the dollar amount of payments withheld (e.g., negative adjustments) since the beginning of the calendar year.

5P. Credit Amount

a. Current Processed — Indicates the dollar amount of any voluntary refunds dispositioned in the previous week.
b. Year-to-Date Total — Indicates the dollar amount of voluntary refunds dispositioned since the beginning of the calendar year.

6P. Net 1099 Amount

a. Current Processed — Indicates the net earnings for the claims shown on this R/S Report.
b. Year-to-Date Total — Indicates the net earnings calculated from the beginning of the calendar year.

ATTACHMENT 2
Sample Remittance and Status Report

REMITTANCE AND STATUS REPORT

WISCONSIN MEDICAID AND BADGERCARE PROGRAMS
6406 Bridge Road | Voice Response 800/947-3544 608/221-4247
Madison, WI 53784 | Policy/Billing 800/947-9627 608/221-9883

1H
I.M. BILLING
ONE WEST WILLIAMS
ANYTOWN, WI 55555

2H
R/S NUMBER 1 2 3 4 5 6 7 8 9

5H

3H
PROVIDER NUMBER 12345678

6H
REPORT SEQ NUMBER 3

DATE MM/DD/YY 4H

PAGE 2

PATIENT NAME/ID NUMBER / SERVICE DATES FROM | TO / U D / N S / PERF PROV/ RX NUMBER	MEDICAL RECORD NO / DAYS QTY	PROC/ACCOM/ DRUG CDE/M1 M2 M3 M4	PATIENT CONTROL NO / CLAIM NUMBER / PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
PAID OR DENIED CLAIMS (1A, 2A, 3A, 4A, 5A)						15A	16A	17A	18A
RECIPIENT IM / 1234567890	1234 JED		124 209892XXXXXXXXX						
110603 110603 (7A) (8A) 81234567	100	99202 TJ	OFFICE / OP VISIT - NEW PATIEN	XXXX	XXXX	XXX	XXX	XXXX	12
110703 110703 81234567	100	99214 TJ	OFFICE / OP VISIT - ESTABLISHE PATIEN	XXXX	XXXX	XXX	XXX	XXXX	12
(6A) (9A) (10A) (11A)			CLAIM TOTAL (12A) (13A) (14A)	XXXX	XXXX	XXX	XXX	XXXXX	
CLAIM TYPE SUB-TOTAL	1			XXXX	XXXX	XXX	XXX	XXXXX	
PAID CLAIM TOTALS	1			XXXX	XXXX	XXXX	XXX	XXXXX	

1R REMINDER: CHECK #0123456789, ISSUED TO YOU MM/DD/YY FOR $2,618.67 REMAINS OUTSTANDING. PLEASE CASH THE CHECK OR CONTACT THE PROVIDER SERVICES UNIT IF THERE IS A PROBLEM.

CLAIMS PAYMENT SUMMARY (1P)

	CLAIMS PAID (2Pa)	CLAIMS AMOUNT (3Pa)	WITHHELD AMOUNT (4Pa)	CREDIT AMOUNT (5Pa)	NET 1099 AMOUNT (6Pa)
CURRENT PROCESSED	1	XXX.XX	00	00	XXXXX
YEAR - TO - DATE TOTAL (2Pb, 3Pb, 4Pb, 5Pb, 6Pb)	56	XXXX.XX	00	00	XXXXXX

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE
12 SERVICE PAID AT THE MAXIMUM AMOUNT ALLOWED BY MEDICAL ASSISTANCE REIMBURSEMENT POLICIES

ATTACHMENT 3

Reading an adjustment on the paper Remittance and Status Report

When either a provider submits an adjustment request on a claim or a Medicaid-generated adjustment occurs on a provider's claim, the adjustment will appear on the provider's Remittance and Status (R/S) Report.

It is vital that providers understand how to read an adjustment on the R/S Report in order to properly balance recipient accounts. The following is a basic description of the layout and information that appears on the R/S Report when an adjustment processes. Refer to Attachment 4 of this *Wisconsin Medicaid and BadgerCare Update* for a sample R/S Report with an adjusted claim.

1. *Previous Claim* — This is the previous claim that was processed for the services. The message, "This is an adjustment to previous claim XXXXXXXXXXXXXXX paid on MMDDYY," indicates when the previous claim processed. The original claim is then printed.

   All item(s) on the previous claim appear with a "-" in front of the dollar amounts. The minus signs appear because the claim is being "reversed" or "negated out" of the processing system to allow the adjustment to be examined. The minus signs on the previous claim do not mean that reimbursement is being taken away.

2. *Adjustment Claim* — The adjustment claim can be identified by a 15-digit claim number beginning with 19, 39, 49, 59, or 79. The adjustment claim is the reprocessing of the previous claim plus the corrections which needed to be made.

   Compare each detail on the previous claim with each corresponding detail on the adjustment claim. If the adjusted detail is reimbursed at a greater amount than the previous claim, additional reimbursement for the difference is made.

3. *601 Receivable* — If the adjusted detail is reimbursed at a lower amount than the previous claim, an accounts receivable will be established. (This is identified by the code "601," "Receivable established for balance of $XXX.XX which will be withheld from future payments.")

Example: In the sample R/S Report which shows an adjustment (Attachment 4), an accounts receivable of $15.23 has been established. This number is based on the following computation:

Paid amount on previous claim =	$15.23
Paid amount on adjusted claim =	$ 0.00
Accounts Receivable	$15.23

ATTACHMENT 4

Sample Remittance and Status Report displaying an adjusted claim

REMITTANCE AND STATUS REPORT

WISCONSIN MEDICAID AND BADGERCARE PROGRAMS
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I.M. BILLING
ONE WEST WILLIAMS
ANYTOWN, WI 55555

R/S NUMBER 123456789

PROVIDER NUMBER 12345678 REPORT SEQ NUMBER 3 DATE MM/DD/YY PAGE 2

PATIENT NAME/ID NUMBER / SERVICE DATES FROM | TO	U D	N S	PERF PROV/ RX NUMBER	MEDICAL RECORD NO / DAYS QTY	PROC/ACCOM/ DRUG CDE/M1 M2 M3 M4	PATIENT CONTROL NO / CLAIM NUMBER / PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
ADJUSTMENT TO CLAIMS						(2)						
RECIPIENT IM / 1234567890 110603 110603 (1)				100	99201	399892XXXXXXXXX	2200	00	00	00	00	743 80
123 THIS IS AN ADJUSTMENT TO PREVIOUS CLAIM 209890XXXXXXXXX PAID ON 120703 RECIPIENT / 1234567890 110603 110603				100	99201	209890XXXXXXXXX	-2200	-1623	00	-100	-1523	118
(3)						CLAIM TOTAL	-2200	-1623	00	-100	-1523	
601 RECEIVABLE ESTABLISHED FOR A BALANCE OF $15.23 WHICH WILL BE WITHHELD FROM FUTURE PAYMENTS CLAIM TYPE SUB-TOTAL				2			00	-1523				
PAID CLAIM TOTALS				1			2200	00		00		
CLAIMS PAYMENT SUMMARY				CLAIMS PAID		CLAIMS AMOUNT	WITHHELD AMOUNT		CREDIT AMOUNT		NET 1099 AMOUNT	
CURRENT PROCESSED				1		.00	00		00		00	
YEAR - TO - DATE TOTAL				2		.00	00		00		00	

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE

80 SERVICE(S) DENIED DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY.

118 PAYMENT RECOUPED FOR PREVIOUS CLAIM INCORRECTLY PAID. NO ACTION REQUIRED.

743 THIS ADJUSTMENT WAS INITITATED BY EDS/DHCF STAFF. IT CORRECTS A MISPAYMENT FOUND DURING CLAIMS PROCESSING OR RESULTING FROM RETROACTIVE FILE CHANGES.