wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Federally Qualified Health Centers

Podiatrists

Rural Health Clinics

HMOs and Other Managed Care Programs

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

This *Wisconsin Medicaid and BadgerCare Update* introduces changes to local codes and paper claims for podiatry 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 CMS 1500 paper claim instructions.

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

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for podiatry 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 procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes or revised paper claim instructions prior to implementation dates may result in claim denials. Specific implementation dates will be published in a future *Update*.

Adoption of national codes

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

Allowable procedure codes

Wisconsin Medicaid will adopt *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W9100-W9105) for routine foot care. The diagnosis codes required for routine foot care will continue to be required for the new routine foot care procedure codes. Refer to the Podiatry Services Handbook for the list of diagnosis codes. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Attachment 2 is a conversion chart for injection procedure codes. This includes codes that will be discontinued. Providers will be required to use the appropriate procedure code that describes the service performed.

Providers should continue to refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers.

Type of service codes

Type of service (TOS) codes will no longer be required on Medicaid claims. As a result, some national modifiers have been adopted to replace the use of TOS codes. Refer to Attachment 3 for a conversion chart of TOS codes to modifiers.

Modifiers

Providers will be required to use nationally recognized modifiers state defined for routine foot care. Refer to Attachment 1 for the new modifiers and the procedure codes to which they apply.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 4 for a list of allowable POS codes for podiatry services.

Coverage for podiatry services

Medicaid coverage and documentation requirements for podiatrists will remain unchanged. Refer to the Podiatry Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified podiatrists will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 5 for the revised instructions. Attachment 6 is a sample of a claim for podiatry 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 CMS 1500 claim form instructions

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Other insurance indicators were revised (Element 9).
- Medicare disclaimer codes were revised (Element 11).
- Outside lab indicator is no longer required (Element 20).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- HealthCheck indicator "H" is no longer required (Element 24H).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

Providers will be required to use nationally recognized modifiers state defined for routine foot care.

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.

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
Procedure code conversion chart for routine foot care

The following table lists the national procedure codes providers will be required to use when submitting claims for routine foot care. Providers should refer to their service-specific *Wisconsin Medicaid and BadgerCare Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers for podiatry services. A future *Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation		**After HIPAA implementation**			
Local procedure code	**Local procedure code description**	**CPT* or HCPCS** procedure code**	**CPT or HCPCS procedure code description**	**Required modifier**	**Place of service (POS)*****
W9100	Patient, office visit	**S0390**	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit	**U1** New patient	05, 06, 07, 08, 11, 50, 71, 72
W9101	Established patient, office visit	**S0390**	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit	**U2** Established patient	05, 06, 07, 08, 11, 50, 71, 72
W9102	First patient, nursing home visit	**S0390**	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit	**U3** First patient, nursing home	31, 32, 33, 54
W9103	Subsequent patients, nursing home visit	**99311**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient	**UA** Routine foot care	31, 32, 33, 54
W9104	New patient, patient's residence	**99341**	Home visit for the evaluation and management of a new patient [per visit]	**UA** Routine foot care	12, 34
W9105	Established patient, patient's residence	**99347**	Home visit for the evaluation and management of an established patient [per visit]	**UA** Routine foot care	12, 34

*CPT — *Current Procedural Terminology*

**HCPCS — HealthCare Common Procedure Coding System

***Refer to Attachment 5 of this *Update* for descriptions of POS codes.

ATTACHMENT 2
Injection codes conversion chart

The following table lists the local procedure codes that will no longer be valid for injections after Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers will be required to use *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting claims for injections. The table indicates procedure code conversions for many of the local codes. In instances where no conversion is indicated, the provider must determine the appropriate nationally recognized CPT or HCPCS code. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of HIPAA.

Before HIPAA implementation	**After HIPAA implementation**
Local procedure code and description	**National procedure code and description**
W6100 Injection, ACTH Gel, 80 units	**Discontinued**
W6102 Injection, Ampicillin (1 g)	**J0295** Injection, ampicillin sodium/sulbactam sodium, per 1.5 g
W6104 Injection, Bicillin CR (900/300)	**J0560** Injection, penicillin G benzathine; up to 600,000 units
W6105 Injection, bicillin C-R, up to 300,000 units	**Discontinued**
W6106 Injection, calcimar, 100 units	**Discontinued**
W6107 Injection, calcimar, 200 units	**Discontinued**
W6109 Injection, calcium chloride, 10 ml	**Discontinued**
W6110 Injection, Cleocin, up to 600 mg	**S0077** Injection, clindamycin phosphate, 300 mg
W6112 Injection, cortrosyn, 0.25 mg	**Discontinued**
W6114 Injection, Depo-Medrol, 60 mg	**J2930** Injection, methylprednisolone sodium sucinate, up to 125 mg
W6115 Injection, Depo-Medrol, 120 mg	**J2930** Injection, methylprednisolone sodium succinate, up to 125 mg
W6120 Injection, Dexamethasone, LA 8 mg/ml	**J1094** Injection, dexamethasone acetate, 1 mg
W6121 Injection, dexamethasone, LA 16 mg	**Discontinued**
W6122 Injection, dextrose, 50 ml	**Discontinued**
W6124 Injection, ephedrine	**Discontinued**
W6126 Injection, furosemide, 20 mg	**Discontinued**
W6127 Injection, furosemide, 40 mg	**Discontinued**
W6128 Injection, furosemide, 80 mg	**Discontinued**

Before HIPAA implementation	After HIPAA implementation
Local procedure code and description	**National procedure code and description**
W6130 Injection, glucagon, 1 mg	**Discontinued**
W6134 Injection, heparin, 10,000 units	**Discontinued**
W6136 Injection, heparin, 20,000 units	**Discontinued**
W6137 Injection, heparin, 5,000 units	**Discontinued**
W6138 Injection, hydrocortisone, 250 mg	**Discontinued**
W6140 Injection, imferon, 1 ml	**Discontinued**
W6141 Injection, imferon, 3 ml	**Discontinued**
W6142 Injection, isoproterenol	**Discontinued**
W6144 Injection, kantrex, 1 g	**Discontinued**
W6146 Injection, kefzol, 1 g	**Discontinued**
W6148 Injection, Magnesium Sulfate	**J3475** Injection, magnesium sulfate, per 500 mg
W6152 Injection, Nubain	**J2300** Injection, nalbuphine HCl, per 10 mg
W6156 Injection, penicillin G procaine, 900,000 units	**Discontinued**
W6157 Injection, Penicillin G Procaine, 1.2 ml units	**J0540** Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units
W6158 Injection, Pencillin G Procaine, 2.4 ml units	**J0550** Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units
W6159 Injection, penicillin G procaine, 4.8 mil units	**Discontinued**
W6160 Injection, penicillin G procaine, 2.4 mil units/probe	**Discontinued**
W6161 Injection, Pencillin G Procaine, 4.8 ml units/probe	**J0550** Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units
W6162 Injection, Procaine	**J0550** Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units
W6168 Injection Stadol	**J3490*** Unclassified drugs
W6170 Injection Susphrine	**J0170** Injection, adrenalin, epinephrine, up to 1 ml ampule
W6172 Injection, tensilon, 5 mg	**Discontinued**

Before HIPAA implementation	After HIPAA implementation
Local procedure code and description	**National procedure code and description**
W6173 Injection, terramycin, 100 mg	**Discontinued**
W6175 Tine/Mantoux/PPD	**86580** Skin test; tuberculosis, intradermal (for testing portion)
	90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous (for the vaccination portion)
W6177 Injection Velban, 2 mg	**J9360** Vinblastine sulfate, 1 mg
W6178 Injection, velban, 5 mg	**Discontinued**
W6179 Injection, velosef, 250 mg	**Discontinued**
W6180 Injection, velosef, 500 mg	**Discontinued**
W6181 Vistaril, 100 mg	**J3410** Injection, hydroxyzine HCl, up to 25 mg

ATTACHMENT 3

Type of service code conversion chart for podiatry services

The following table lists the nationally recognized modifiers Medicaid providers must use in lieu of type of service (TOS) codes when submitting claims for podiatry services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of specific effective dates of Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Category	Before HIPAA implementation	After HIPAA implementation
	TOS code and description	**National modifier and description**
Technical component of podiatry services	Podiatry services billed with TOS code "**U**"	**TC** Technical component
Professional component of podiatry services	Podiatry services billed with TOS codes "**Q**," "**S**," "**T**," "**W**," or "**X**"	**26** Professional component
Surgical assistance	Podiatry services billed with TOS code "**8**"	**80** Assistant surgeon
Other podiatry services	Podiatry services billed with TOS codes "**1**," "**2**," "**3**," "**4**," "**5**," "**6**," "**9**," or "**K**"	No modifier needed for medical, surgery, consultation, complete, or other services

ATTACHMENT 4
Place of service codes for podiatry services

The following tables list the allowable place of service (POS) codes that providers should use when submitting claims after Wisconsin Medicaid's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Evaluation and management, medicine, and surgery services	
POS code	**Description**
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
51	Inpatient Psychiatric
54	Intermediate Care Facility/Mentally Disabled
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

Laboratory services	
POS code	**Description**
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Disabled
71	State or Local Public Health Clinic
72	Rural Health Clinic

Radiology services	
POS code	**Description**
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Disabled
71	State or Local Public Health Clinic
72	Rural Health Clinic

ATTACHMENT 5
CMS 1500 claim form instructions for podiatry services

(For claims received after HIPAA implementation)

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

Wisconsin Medicaid recipients receive a Medicaid identification card upon being 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.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

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

Element 2 — Patient's 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.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

If the EVS indicates that the recipient has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that 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 health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 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 bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank 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 that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are 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 dates of service (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).

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

When appropriate, enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required. Refer to the Podiatry Services Handbook for a list of acceptable diagnosis codes.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing **only** the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG

Enter an "E" for **each** procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

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

Element 32 — Name and Address of Facility Where Services Were Rendered

If the services were provided to a recipient in a nursing home (POS code "31," "32," "33," or "54"), indicate the nursing home's eight-digit Wisconsin Medicaid provider number.

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, address, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 6

Sample CMS 1500 claim form for podiatry services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Attending

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 56781234

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.7 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 10 03		11		S0390	U1	1	XX XX	1.0				12345678
2 11 17 03		12		99347	UA	1	XX XX	1.0				12345678
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 00 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)