To:
Community Care Organizations

# Changes to local codes and paper claims for Community Care Organizations as a result of HIPAA

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/*.

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for Community Care Organizations, 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 separate *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 Community Care Organizations. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A separate *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 a nationally recognized procedure code and place of service (POS) code to replace currently used Wisconsin Medicaid local codes.

- Revising CMS 1500 paper claim instructions.

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

## Adoption of national codes

Wisconsin Medicaid will adopt a nationally recognized Healthcare Common Procedure Coding System (HCPCS) procedure code to replace currently used Wisconsin Medicaid local codes for Community Care Organizations.

### *Allowable procedure codes*

Wisconsin Medicaid will adopt HCPCS procedure code G9002 to replace currently used Wisconsin Medicaid local procedure codes (W6301-W6303) for Community Care Organizations. Refer to Attachment 1 of this *Update* for a procedure code conversion chart.

### *Type of service codes*

Type of service codes will no longer be required on Medicaid claims.

*Place of service codes*

Nationally recognized two-digit POS code "88" (not applicable) will replace the one-digit Wisconsin Medicaid POS codes.

## Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified Community Care Organizations 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 2 for the revised instructions. Attachment 3 is a sample of a claim for Community Care Organizations 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).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

## 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.

Nationally recognized two-digit POS code "88" (not applicable) will replace the one-digit Wisconsin Medicaid POS codes.

# ATTACHMENT 1
# Procedure code conversion chart for Community Care Organizations

The following table lists the nationally recognized procedure code that Community Care Organizations will be required to use when submitting claims. A future *Wisconsin Medicaid and BadgerCare 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** | **HCPCS\* procedure code** | **HCPCS procedure code description** |
| W6301 | Community Care Organization administrative fee — Milwaukee | **G9002** | Coordinated care fee, maintenance rate |
| W6302 | Community Care Organization administrative fee — Barron | | |
| W6303 | Community Care Organization administrative fee — La Crosse | | |

\*HCPCS = HealthCare Common Procedure Coding System.

# ATTACHMENT 2
# CMS 1500 claim form instructions for Community Care Organizations
### (For claims submitted 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 "M" 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:<br>✓ The recipient denied coverage or will not cooperate.<br>✓ The provider knows the service in question is not covered by the carrier.<br>✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims.<br>✓ Benefits are not assignable or cannot get assignment.<br>✓ 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:<br>*For Medicare Part A (all three criteria must be met):*<br>✓ 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.<br>✓ The recipient is eligible for Medicare Part A.<br>✓ The procedure provided is covered by Medicare Part A.<br>*For Medicare Part B (all three criteria must be met):*<br>✓ 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.<br>✓ The recipient is eligible for Medicare Part B.<br>✓ 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:<br>*For Medicare Part A (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.<br>✓ The recipient is eligible for Medicare Part A.<br>✓ 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.<br>*For Medicare Part B (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.<br>✓ The recipient is eligible for Medicare Part B.<br>✓ 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:<br>*For Medicare Part A (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.<br>✓ The recipient is eligible for Medicare Part A.<br>✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis).<br>*For Medicare Part B (all three criteria must be met):*<br>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.<br>✓ The recipient is eligible for Medicare Part B.<br>✓ 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 (not required)**

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

**Element 19 — Reserved for Local Use (not required)**

**Element 20 — Outside Lab? (not required)**

**Element 21 — Diagnosis or Nature of Illness or Injury**

Enter diagnosis code V68.9 (unspecified encounter for administrative purposes). The diagnosis description is not required.

**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 multiple DOS for the same calendar month and on the same detail line, enter the month's first DOS in MM/DD/YY format in the "From" field. Enter the month's last DOS in the "To" field in MM/DD/YY format.

**Element 24B — Place of Service**

Enter place of service code "88" (not applicable).

**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.

**Element 24E — Diagnosis Code**

Enter the number "1" to correspond to the diagnosis code in Element 21.

**Element 24F — $ Charges**

Enter the total charge for each line item.

**Element 24G — Days or Units**

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

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

**Element 24I — EMG (not required)**

**Element 24J — COB (not required)**

**Element 24K — Reserved for Local Use (not required)**

**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 (not required)

## 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, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

# ATTACHMENT 3
## Sample CMS 1500 claim form for Community Care Organizations

| | PICA | | | | | | **HEALTH INSURANCE CLAIM FORM** | | PICA | | |

**1. MEDICARE** ☐ (Medicare #)   **MEDICAID** ☒ (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 ☒

**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 ☐

**CITY**   **STATE**

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

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

**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** FROM MM DD YY TO MM DD YY

**17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

**17a. I.D. NUMBER OF REFERRING PHYSICIAN**

**18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** FROM MM DD YY 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. V68.9
2. ____.__
3. ____.__
4. ____.__

**22. MEDICAID RESUBMISSION CODE**   ORIGINAL REF. NO.

**23. PRIOR AUTHORIZATION NUMBER**

| 24. A DATE(S) OF SERVICE From — To | | | | | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MM | DD | YY | MM | DD | YY | | | | | | | | | | | |
| 1 | 01 01 04 | | 01 31 04 | | | 88 | | G9002 | | 1 | XXX XX | 31 | | | | |
| 2 | | | | | | | | | | | | | | | | |
| 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** $ 0 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#

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