

To:
End Stage Renal
Disease
Providers
Outpatient
Hospital
Providers
Rural Health
Clinics
HMOs and Other
Managed Care
Programs

HCPCS Procedure Code No Longer Required for Outpatient Hospital Services

Effective immediately, Wisconsin Medicaid no longer requires a Healthcare Common Procedure Coding System (HCPCS) procedure code to be indicated on claims for outpatient hospital services. A HCPCS procedure code is still required for outpatient laboratory services as identified by revenue categories 030X and 031X and revenue codes 0923 and 0925.

HCPCS Procedure Code Still Required for Outpatient Laboratory Services

Effective immediately, Wisconsin Medicaid no longer requires a Healthcare Common Procedure Coding System (HCPCS) procedure code to be indicated on claims for outpatient hospital services as stated in previous *Wisconsin Medicaid and BadgerCare Updates*.

Wisconsin Medicaid still requires a HCPCS procedure code for outpatient laboratory services (identified by revenue categories 030X and 031X and revenue codes 0923 and 0925), as was Wisconsin Medicaid's requirement prior to changes implemented with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Revised Electronic and Paper Billing Instructions

Refer to Attachments 1 and 2 of this *Update* for the modified instructions for the UB-92 (80 Byte) Record Layout and the UB-92 (192 Byte) Record Layout. These instructions replace instructions that were published in the September 2003 *Update* (2003-146), titled "HIPAA contingency plan: options for billing services and providers who will not be ready to submit HIPAA-compliant electronic claims."

Refer to Attachment 3 for the revised UB-92 (CMS 1450) paper claim instructions. Attachment 4 is a sample of a claim for outpatient hospital services. These attachments replace Attachments 3 and 5 in the July 2003 *Update* (2003-73), titled "Changes to local codes, paper claims, and prior authorization for hospital services as a result of HIPAA."

Instructions in Attachments 1 through 3 also apply to provider-submitted Medicare crossover claims.

The information in this *Wisconsin Medicaid and BadgerCare Update* also applies to providers participating in the Health Insurance Risk Sharing Plan (HIRSP).

Denied Claims

For outpatient hospital claims submitted without HCPCS procedure codes, providers might have received the following denials:

- On the paper Remittance and Status (R/S) Report, Explanation of Benefits (EOB) message 402, stating “Claim or adjustment/reconsideration must have both a revenue and either a HCPCS or CPT-4 code.”
- On the 835 Health Care Claim Payment/Advice transaction (835), both of the following:
 - ✓ Reason Code 125, stating “Payment adjusted due to a submission/billing error(s).”
 - ✓ Remark Code M50, stating “Incomplete/invalid revenue code(s)” or Remark Code M67, stating “Incomplete/invalid other procedure code(s) and/or dates.”

Providers may resubmit these claims to Wisconsin Medicaid in accordance with the billing instructions provided in this *Update*.

HIRSP Claims

To ensure that HIRSP policyholders were not billed for services that were previously denied to the provider with the above indications (i.e., EOB message 402, Reason Code 125, Remark Codes M50 and M67), denied services were automatically resubmitted for processing. Providers should refer to recent HIRSP R/S Reports for reprocessing results.

Claims Submission

Wisconsin Medicaid must receive all claims within 365 days of the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

For More Information

For questions about this *Update*, providers may contact Provider Services at (800) 947-9627 or (608) 221-9883.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at dhfs.wisconsin.gov/medicaid/.

PHC 1250

ATTACHMENT 1

Modified Instructions for Claims Submitted Using the UB-92 (80 Byte) Record Layout on and After October 13, 2003

For claims submitted to Wisconsin Medicaid using the UB-92 (80 Byte) Record Layout on and after October 13, 2003, billing services and providers will be required to follow the current record layout with the following modifications and clarifications.

CLAIMS SUBMISSION

When submitting claims using the UB-92 (80 Byte) Record Layout, continue to use the dial-up connection and data exchange methods allowed prior to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Round-reel [9-track] tapes; 3480, 3490, and 3490E cartridge tapes; CD-ROM; 3780 protocol; Micro-ECS; and Reformatter).

MEDICAL CODES

Providers should continue to use medical codes (e.g., procedure codes, modifiers) appropriate to the date of service (DOS). Refer to Attachment 4 of the September 2003 *Update* (2003-146), titled “HIPAA contingency plan: options for billing services and providers who will not be ready to submit HIPAA-compliant electronic claims,” for medical codes that change as a result of HIPAA.

CLAIM HEADER RECORD 1

Field 3 — TOB

Despite changes as a result of HIPAA, continue to follow the UB-92 (80 Byte) Record Layout specifications.

CLAIM HEADER RECORD 2

Field 12 — OI

Indicate “OI-Y” in place of “OI-H.”

CLAIM HEADER RECORD 3

Fields 3-12 — VALUE-1/AMOUNT-1 — VALUE-5/AMOUNT-5

Do not indicate value code “22” or the associated amount for spenddown. Wisconsin Medicaid will automatically reduce the provider’s reimbursement by the amount of the recipient’s spenddown amount.

Continue to indicate value code “84” and the associated amount for patient liability.

CLAIM HEADER RECORD 4

Fields 3-12 — OCC-1/OCC-DATE-1 — OCC-5/OCC-DATE-5

Do not indicate occurrence codes “50” and “51” for mother/baby claims. Refer to the June 2003 *Update* (2003-29), titled “Wisconsin Medicaid will no longer reimburse claims submitted for newborns under the mother's identification number,” for more information.

Fields 13-17 — CND-1 — CND-5

Indicate the applicable condition codes appropriate to the DOS.

CLAIM DETAIL RECORD 7

Field 4 — FDOS

Special Instructions for Hospital Providers

List a single DOS for each detail in MMDDYY format.

Field 6 — HCPCS

Indicate the appropriate Healthcare Common Procedure Coding System or *Current Procedural Terminology* code for home health and personal care providers.

Fields 7-8 — M1 and M2

Claims that require more than two modifiers cannot be submitted using the UB-92 (80 Byte) Record Layout. If a claim requires more than two modifiers, submit the claim using the 837 Health Care Claim: Institutional transaction or the paper UB-92.

Fields 9 — LOC/ANC/REV

Indicate the appropriate code for all providers.

Despite changes as a result of HIPAA, continue to follow the UB-92 (80 Byte) Record Layout specifications by indicating the appropriate three-digit revenue code.

Special Instructions for Hospital Providers

Do *not* indicate procedure codes W9111-W9115; instead, indicate revenue code 81X regardless of the DOS.

Special Instructions for Nursing Home Providers

For DOS before October 1, 2003, indicate the appropriate two-digit local level of care code and follow the format of the UB-92 (80 Byte) Record Layout specifications. For DOS on and after October 1, 2003, drop the first zero when indicating the appropriate revenue code.

MAX DETAILS

Despite changes as a result of HIPAA, continue to follow the UB-92 (80 Byte) Record Layout specifications.

ATTACHMENT 2

Modified Instructions for Claims Submitted Using the UB-92 (192 Byte) Record Layout on and After October 13, 2003

For claims submitted to Wisconsin Medicaid using the UB-92 (192 Byte) Record Layout on and after October 13, 2003, billing services and providers will be required to follow the current record layout with the following modifications and clarifications.

CLAIMS SUBMISSION

When submitting claims using the UB-92 (192 Byte) Record Layout, continue to use the dial-up connection and data exchange methods allowed prior to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Round-reel [9-track] tapes; 3480, 3490, and 3490E cartridge tapes; CD-ROM; 3780 protocol; Micro-ECS; and Reformatter).

MEDICAL CODES

Providers should continue to use medical codes (e.g., procedure codes, modifiers) appropriate to the date of service (DOS). Refer to Attachment 4 of the September 2003 *Update* (2003-146), titled "HIPAA contingency plan: options for billing services and providers who will not be ready to submit HIPAA-compliant electronic claims," for medical codes that change as a result of HIPAA.

KEY TO RECORDS

Bill Type

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications.

Record Limit

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications.

Record Type: 01

Field 19 — Vendor Number

Continue to indicate the appropriate pre-HIPAA vendor number.

Record Type: 10

Field 2 — Type of Batch

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications.

Record Type: 20

Field 24 — Estimated Amount Due

Do not use this field to indicate patient liability in the UB-92 (192 Byte) Record Layout. (Refer to Record Type: 41, Fields 16-39.)

Record Type: 22

Field 13 — Other Insurance Indicator and Medicare Status Code

Indicate “OI-Y” in place of “OI-H.”

Record Type: 30

Field 26 — Estimated Amount Due

Do not use this field to indicate patient liability in the UB-92 (192 Byte) Record Layout. (Refer to Record Type: 41, Fields 16-39.)

Record Type: 40

Fields 8-27 — Occurrence Code 1/Occurrence Date 1 — Occurrence Code 10/Occurrence Date 10

Do not indicate occurrence codes “50” and “51” for mother/baby claims. Refer to the June 2003 *Update* (2003-29), titled “Wisconsin Medicaid will no longer reimburse claims submitted for newborns under the mother's identification number,” for more information.

Record Type: 41

Fields 4-13 — Condition Code 1 — Condition Code 10

Indicate the applicable condition codes appropriate to the DOS.

Fields 16-39 — Value Code 1/Value Amount 1 — Value Code 12/Value Amount 12

Do not indicate value code “22” or the associated amount for spenddown. Wisconsin Medicaid will automatically reduce the provider’s reimbursement by the amount of the recipient’s spenddown amount.

Continue to indicate value code “84” and the associated amount for patient liability.

Record Type: 50

Field 4 — Accommodation Revenue Code 1

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications by indicating the appropriate three-digit revenue code.

Record Type: 55

Field 4 — Accommodation/Ancillary 1

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications by indicating the appropriate three-digit revenue code.

Special Instructions for Nursing Home Providers

For DOS before October 1, 2003, indicate the appropriate two-digit local level of care code and follow the format of the UB-92 (192 Byte) Record Layout specifications. For DOS on and after October 1, 2003, drop the first zero when indicating the appropriate revenue code and follow the format of the UB-92 (192 Byte) Record Layout specifications.

Record Type: 60

Field 4 — Ancillary Revenue Code 1

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications by indicating the appropriate three-digit revenue code.

Special Instructions for Hospital Providers

Do *not* indicate procedure codes W9111-W9115; instead, indicate revenue code 81X regardless of the DOS and follow the format of the UB-92 (192 Byte) Record Layout specifications.

Record Type: 61

Field 4 — Revenue Center Code 1

Indicate the appropriate code for home health, personal care, and outpatient hospital providers.

Despite changes as a result of HIPAA, continue to follow the UB-92 (192 Byte) Record Layout specifications by indicating the appropriate three-digit revenue code.

Field 5 — HCPCS Procedure Code

Indicate the appropriate Healthcare Common Procedure Coding System or *Current Procedural Terminology* code for home health and personal care providers.

Fields 6-7 — Modifier 1 and Modifier 2

Claims that require more than two modifiers cannot be submitted using the UB-92 (192 Byte) Record Layout. If a claim requires more than two modifiers, submit the claim using the 837 Health Care Claim: Institutional transaction or the paper UB-92.

Field 9 — Date of Service

Special Instructions for Hospital Providers

List a single DOS for each detail in MMDDYY format.

Field 13 — Date of Service (For Record Layout Version 6.0 only)

Special Instructions for Hospital Providers

List a single DOS for each detail in CCYYMMDD format.

ATTACHMENT 3

UB-92 (CMS 1450) Claim Form

Instructions for Hospital 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 form for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Uniform 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 dhfs.wisconsin.gov/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. The 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 (required, if applicable)

Enter the Pre-Admission Review control number as required.

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

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. Some of the bill numbers for hospitals include the following:

- 111 = Hospital, Inpatient, Admit Through Discharge Claim
- 131 = Hospital, Outpatient, Admit Through Discharge Claim
- 851 = Special Facility, Critical Access Hospital (Inpatient and Outpatient Hospitals), Admit Through Discharge Claim

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

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., January 2, 2004, would be 010204).

Form Locator 7 — Cov D.

Enter the total number of days covered by the primary payer, as qualified by the payer organization.

For Inpatient Claims

For inpatient claims, do not count the day of discharge.

For Outpatient Claims

For outpatient claims, covered days must represent the actual number of visits (days of service) in the “from - through” period.

Form Locator 8 — N-C D. (required for inpatient claims)

Enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the “from - through” period.

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 (required for inpatient claims)**

Enter the admission date in MM/DD/YY format (e.g., January 2, 2004, would be 010204).

Form Locator 18 — Admission Hr (not required)**Form Locator 19 — Admission Type (required for inpatient claims)**

Enter the appropriate admission type for inpatient hospital services. Admission type is not required for outpatient hospital services.

Form Locator 20 — Admission Src

Enter the code indicating the source of this admission.

Form Locator 21 — D Hr (not required)**Form Locator 22 — Stat (required for inpatient claims)**

Enter the code indicating patient status as of the “Statement Covers Period” through date from Form Locator 6.

Form Locator 23 — Medical Record No. (required for inpatient claims)

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)**Form Locator 31 — Unlabeled Field (not required)****Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)****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:

- 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.

Refer to the Hospital Services Handbook for information regarding inpatient dual-entitlee billing instructions for partial or no Part A benefits.

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 (not required)**Form Locator 44 — HCPCS/Rates (required, if applicable)**

For outpatient laboratory services identified by revenue categories 030X and 031X and revenue codes 0923 and 0925, enter the appropriate corresponding Healthcare Common Procedure Coding System code.

Form Locator 45 — Serv. Date (not required)**Form Locator 46 — Serv. Units**

Enter the number of covered accommodations days, ancillary units of service, or visits, where appropriate.

Form Locator 47 — Total Charges

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, “statement covers period.” 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 commercial health insurance.

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 health 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 health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due (not required)**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 (required, if applicable)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

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 complete *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) 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). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis.

For Inpatient Claims

The principal diagnosis selected must be the reason for admission. It should relate to one or more conditions or symptoms identified in the admission notes and/or admission work-up. Manifestation codes are not to be recorded as the principal diagnosis; code the underlying disease first. The principal diagnosis code may not include “E” codes. “V” codes may be used as the principal diagnosis.

For Outpatient Claims

The principal diagnosis identifies the condition chiefly responsible for the patient’s visit or treatment. The principal diagnosis code may not include “E” codes. “V” codes may be used as the principal diagnosis.

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. (required for inpatient claims)

Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

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 (required, if applicable)**

Enter the procedure code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.

Note: Most often the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

Form Locator 81 — Other Procedure Code and Date (required, if applicable)

If more than six procedures are performed, report those that are most important for the episode using the same guidelines in Form Locator 80 for determining the principal procedure.

Form Locator 82 a-b — Attending Phys. ID

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

Form Locator 83 a-b — Other Phys. ID

Enter the UPIN or license number and name.

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.

When the recipient has dental (“DEN”), Medicare Cost (“MCC”), Medicare + Choice (“MPC”) insurance only, 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 or commercial HMO. 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: <ul style="list-style-type: none">✓ 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 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.

Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers are required to be Medicare certified to perform Medicare-covered services for dual entitlements.

- 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 above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	<p>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 before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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.

Code	Description
M-7	<p>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:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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	<p>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:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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). <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ 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, or a signature stamp.

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 4

Sample UB-92 Claim Form for Outpatient Hospitals

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234		2		3 PATIENT CONTROL NO.				4 TYPE OF BILL 131									
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 020404		6 STATEMENT COVERS PERIOD THROUGH 020404		7 COV D 1									
12 PATIENT NAME RECIPIENT, IMA H.		13 PATIENT ADDRESS															
14 BIRTHDATE		15 SEX		16 MS		17 DATE		ADMISSION 18 HR 19 TYPE 20 SRC 3 1									
21 D HR		22 STAT		23 MEDICAL RECORD NO.		24 CONDITION CODES 25 26 27 28 29 30 31											
32 OCCURRENCE DATE		34 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 A B C											
39 CODE		41 CODE		VALUE CODES AMOUNT		41 VALUE CODES 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 0300				80053				1		XX XX				1			
2 0310				80048				1		XX XX				2			
3 0450								1		XX XX				3			
4 0923				88142				1		XX XX				4			
5 0925				81025				1		XX XX				5			
6														6			
7														7			
8														8			
9														9			
10														10			
11														11			
12														12			
13														13			
14														14			
15														15			
16														16			
17														17			
18														18			
19														19			
20														20			
21														21			
22 0001		Total Charges								XXX XX				22			
23														23			
50 PAYER A 45009 BLUE CROSS B T19 MEDICAID C		51 PROVIDER NO. BC111 87654321		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS XX XX		55 EST AMOUNT DUE XX XX		56					
57		DUE FROM PATIENT ▶															
58 INSURED'S NAME		59 P.REL		60 CERT. - SSN - HIC - ID NO. 1234567890				61 GROUP NAME		62 INSURANCE GROUP NO.							
A		B		C		A		B		C		A		B		C	
63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME				66 EMPLOYER LOCATION									
A		B		C		A		B		C		A		B		C	
67 PRIN DIAG CD V288		68 CODE		70 CODE		OTHER DIAG. CODES 72 CODE		74 CODE		75 ADM DIAG. CD		77 E-CODE		78			
79 P.C		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID		83 OTHER PHYS. ID A12345 I.M. Referring, M.D.									
a		b		c		a		b		c		a		b		c	
84 REMARKS b OI-P		85 PROVIDER REPRESENTATIVE x Ima H Provider		86 DATE 021904													

UB-92 HCFA-1450

OCR / Original

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