wisconsin Medicaid update and BadgerCare

July 2004 ● No. 2004-57

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Hospice Providers
Nursing Homes
HMOs and Other Managed Care Programs

Submitting Adjustment Requests for Retroactive Rate Changes

Effective for dates of service on and after July 1, 2003, hospice providers may submit adjustment requests to receive additional reimbursement based on retroactive rate increases for nursing home room and board (revenue code 0169).

Effective for dates of service (DOS) on and after July 1, 2003, hospice providers may submit adjustment requests to receive additional reimbursement based on retroactive rate increases for nursing home room and board (revenue code 0169).

When a nursing home's skilled nursing facility (SNF) rate is retroactively increased, hospice providers may submit an adjustment request for each affected claim. Wisconsin Medicaid will process adjustments so that the amount paid to hospice providers reflects 95 percent of the new SNF rate.

Hospice providers should ask their contracted nursing homes to notify them when the SNF rate is retroactively changed.

Receiving Retroactive Rate Increases

Wisconsin Medicaid must receive all adjustment requests within 365 days of the DOS. Adjustment requests for these retroactive rate increases that are beyond the 365-day timely filing deadline may be submitted to Timely Filing Appeals; however, they must be received by Wisconsin Medicaid before December 1, 2004.

Submitting Adjustment Requests

To receive retroactive rate increases, hospice providers should complete the Adjustment/ Reconsideration Request form, HCF 13046 (Rev. 06/03). Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for a copy of the form and instructions. Attachment 3 is a sample of an Adjustment/ Reconsideration Request form submitted for a retroactive rate increase. In Element 16 of the form, hospice providers should check "Other/ Comments" and write "to obtain retroactive rate increase for nursing home room and board (per *Update* 2004-57)." Adjustment requests should be sent to the address indicated on the form.

Hospice providers are reminded that adjustment requests may be submitted electronically using the 837 Health Care Claim: Professional transaction; however, Timely Filing Appeals Requests must be submitted on paper.

Submitting Timely Filing Appeals Requests

To receive retroactive rate increases for DOS that are beyond the 365-day timely filing deadline, a completed Timely Filing Appeals Request form, HCF 13047 (Rev. 06/03) must

be received by Wisconsin Medicaid before December 1, 2004. Refer to Attachment 4 for a copy of the form. Attachment 5 is a sample of a Timely Filing Appeals Request form submitted for a retroactive rate increase. When completing the form, hospice providers should write "to obtain retroactive rate increase for nursing home room and board (per *Update* 2004-57)" to explain the nature of the problem. A Timely Filing Appeals Request should be sent with an Adjustment/Reconsideration Request to the address indicated on the Timely Filing Appeals Request form.

Obtaining Forms

The Adjustment/Reconsideration Request form may be photocopied from Attachment 2. The Timely Filing Appeals Request form may be photocopied from Attachment 4.

Both forms are also available in a fillable Portable Document Format (PDF) from the forms section of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. The fillable PDFs may be accessed using Adobe Acrobat Reader®* and completed electronically. To use a fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of either form, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services.

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.

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*The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat® is obtained, providers may save completed PDFs to their computer. Refer to the Adobe® Web site, *www.adobe.com/*, for more information about fillable PDFs.

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
Adjustment/Reconsideration Request Completion Instructions

(A copy of the "Adjustment/Reconsideration Request Completion Instructions" are located on the following pages.)

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WISCONSIN MEDICAID

ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires the information supplied/requested on this form to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The Adjustment/Reconsideration Request is used by both Wisconsin Medicaid and SeniorCare to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

The Adjustment/Reconsideration Request is reviewed by Wisconsin Medicaid based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

INSTRUCTIONS

Type or print clearly.
Enter the following information from the provider's Remittance and Status (R/S) Report or the 835 Health Care Claim Payment/Advice transaction.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

Element 1 — Name — Billing Provider
Enter the billing provider's name.

Element 2 — Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit Medicaid provider number to which the claim was paid.

Element 3 — Name — Recipient
Enter the complete name of the recipient for whom payment was received.

Element 4 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number.

SECTION II — CLAIM INFORMATION

Element 5 — Remittance and Status (R/S) Report Date / Check Issue Date
Enter the date of the R/S Report or the check issue date from the 835 Health Care Claim Payment/Advice transaction showing the paid claim the provider is adjusting.

Element 6 — Internal Control Number / Payer Control Number (15 digits)
Enter the internal control number (ICN) from the R/S Report or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the claim number assigned to the most recently processed claim or adjustment.)

Add a service line(s).
Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Element 7 — Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service (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 in the same month 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(s), if applicable.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The billed amount for all procedures is identical.
- The number of services performed on each DOS is identical.
- All procedures have the same family planning indicator, if applicable.
- All procedures have the same emergency indicator, if applicable.

Element 8 — POS
Enter the appropriate two-digit POS code for each service.

Element 9 — Procedure Code / NDC / Revenue Code
Enter the single most appropriate procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code/national drug code/revenue code.

Element 10 — Modifiers 1-4
Enter the appropriate modifier(s).

Element 11 — Billed Amount
Enter the total billed amount for each line item. Providers are 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 12 — Unit Quantity
Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 13 — Family Plan
Enter an "F" for each family planning procedure.

Element 14 — EMG
Enter an "E" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 15 — Performing Provider
Enter the eight-digit Medicaid provider number of the performing provider for each procedure if applicable.

SECTION III — ADJUSTMENT INFORMATION

Element 16 — Reason for Adjustment
Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire Medicaid payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the patient was a nursing home resident on the DOS, or the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Explanation of Medicare Benefits (EOMB), or comparable provider-generated explanation of payment containing the same information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other/Comments.* Add any clarifying information not included above.*

Element 17 — Signature — Provider**
Authorized signature of the provider.

Element 18 — Date Signed**
Use either the MM/DD/YY format or the MM/DD/YYYY format.

Element 19 — Claim Form Attached
Indicate if a corrected claim form is attached. Although this is optional, Wisconsin Medicaid encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

*If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.
**If the date or signature is missing on the Adjustment/Reconsideration Request Form, the adjustment request will be denied.

The provider should maintain a copy of this form for his or her records.

ATTACHMENT 2
Adjustment/Reconsideration Request

(A copy of the "Adjustment/Reconsideration Request" is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13046 (Rev. 06/03)

WISCONSIN MEDICAID
ADJUSTMENT / RECONSIDERATION REQUEST

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Name — Billing Provider	2. Billing Provider's Medicaid Provider Number
3. Name — Recipient	4. Recipient Medicaid Identification Number

SECTION II — CLAIM INFORMATION

5. Remittance and Status (R/S) Report Date / Check Issue Date	6. Internal Control Number / Payer Claim Control Number

❑ Add new service line(s) to previously paid/allowed claim (in Elements 7-15, enter information to be added).

7. Date(s) of Service From	To	8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4 Mod 1	Mod 2	Mod 3	Mod 4	11. Billed Amount	12. Unit Quantity	13. Family Plan	14. EMG	15. Performing Provider

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment:
- ❑ Consultant review requested.
- ❑ Recoup entire Medicaid payment.
- ❑ Other Insurance Payment (OI-P) **$**_____.
- ❑ Copayment deducted in error: ❑ Patient in nursing home. ❑ Covered days _____. ❑ Emergency.
- ❑ Medicare reconsideration (Attach the Explanation of Medicare Benefits).
- ❑ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
- ❑ Other/Comments:

17. **SIGNATURE** — Provider	18. Date Signed
Mail to: Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002	19. Claim Form Attached (Optional) ❑ Yes ❑ No

Maintain a copy of this form for your records.

ATTACHMENT 3
Sample Adjustment/Reconsideration Request

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13046 (Rev. 06/03)

WISCONSIN MEDICAID
ADJUSTMENT / RECONSIDERATION REQUEST

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Name — Billing Provider	2. Billing Provider's Medicaid Provider Number
I M Hospice Provider	**87654321**
3. Name — Recipient	4. Recipient Medicaid Identification Number
Recipient Name	**0987654321**

SECTION II — CLAIM INFORMATION

5. Remittance and Status (R/S) Report Date / Check Issue Date	6. Internal Control Number / Payer Claim Control Number
MM/DD/YY	**123456789012345**

❑ Add new service line(s) to previously paid/allowed claim (in Elements 7-15, enter information to be added).

7. Date(s) of Service From	To	8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4 Mod 1	Mod 2	Mod 3	Mod 4	11. Billed Amount	12. Unit Quantity	13. Family Plan	14. EMG	15. Performing Provider

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment:
- ❑ Consultant review requested.
- ❑ Recoup entire Medicaid payment.
- ❑ Other Insurance Payment (OI-P) $_____.
- ❑ Copayment deducted in error: ❑ Patient in nursing home. ❑ Covered days _____. ❑ Emergency.
- ❑ Medicare reconsideration (Attach the Explanation of Medicare Benefits).
- ❑ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
- **X** Other/Comments:

To obtain retroactive rate increase for nursing home room and board (per *Update* 2004-57).

17. **SIGNATURE** — Provider	18. Date Signed
I M Hospice Provider	**MM/DD/YY**
Mail to: Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002	19. Claim Form Attached (Optional) ❑ Yes ❑ No

Maintain a copy of this form for your records.

ATTACHMENT 4
Timely Filing Appeals Request

(A copy of the "Timely Filing Appeals Request" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13047 (Rev. 06/03)

WISCONSIN MEDICAID
TIMELY FILING APPEALS REQUEST

Instructions: Type or print clearly. The provider should complete the Timely Filing Appeals Request and submit it with the claim or adjustment form and attachments to: Wisconsin Medicaid, Timely Filing Appeals Unit, Suite 50, 6406 Bridge Road, Madison, WI 53784-0050.

The attached claim / adjustment meets one or more of the following criteria that are considered for late processing approval (check the appropriate statement):

❑ Claim(s) denied for an eligibility-related explanation of benefits (EOB), reason, remark, or National Council for Prescription Drug Programs (NCPDP) reject code.
Claim number / payer claim control number, _____, originally processed on the Remittance and Status (R/S) Report or the 835 Health Care Claim Payment / Advice transaction number _____ R/S / check issue date _____ (attach R/S if available and one of the following items documenting eligibility: a copy of the magnetic stripe card reader printout, Automated Voice Response log number, or a copy of a paper temporary or Presumptive Eligibility card).

❑ Nursing home level of care / liability amount changes.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 Health Care Claim Payment / Advice transaction number _____ R/S / check issue date _____ (R/S attached if available).
New level of care _____
New liability amount _____

❑ Retroactive recipient eligibility for Wisconsin Medicaid (attach appropriate documentation for retroactive period, if available).

❑ Retroactive eligibility for general relief.

❑ Other insurance / Medicare recoupment (recoupment dated _____ attached).

❑ Medicare denial or reconsideration (reconsideration date _____ attached).

❑ Medicaid reconsideration.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 Health Care Claim Payment / Advice transaction number _____ R/S / check issue date _____ (R/S attached if available).

❑ Fair hearing decision, with signature dated _____ (complete copy attached).

❑ Court order, with signature dated _____ (complete copy attached).

Briefly explain the nature of the problem and previous efforts made to resolve the claims.

SIGNATURE — Provider	Date Signed

Continued

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Claims Submission section of the All-Provider Handbook and the applicable service-specific handbook for service restrictions and additional documentation requirements.

Attach the completed Timely Filing Appeals Request to the claim or adjustment form and attachments and submit them to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Timely Filing
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

ATTACHMENT 5
Sample Timely Filing Appeals Request

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13047 (Rev. 06/03)

WISCONSIN MEDICAID
TIMELY FILING APPEALS REQUEST

Instructions: Type or print clearly. The provider should complete the Timely Filing Appeals Request and submit it with the claim or adjustment form and attachments to: Wisconsin Medicaid, Timely Filing Appeals Unit, Suite 50, 6406 Bridge Road, Madison, WI 53784-0050.

The attached claim / adjustment meets one or more of the following criteria that are considered for late processing approval (check the appropriate statement):

❑ Claim(s) denied for an eligibility-related explanation of benefits (EOB), reason, remark, or National Council for Prescription Drug Programs (NCPDP) reject code.
Claim number / payer claim control number, _____, originally processed on the Remittance and Status (R/S) Report or the 835 Health Care Claim Payment / Advice transaction number _____ R/S / check issue date _____ (attach R/S if available and one of the following items documenting eligibility: a copy of the magnetic stripe card reader printout, Automated Voice Response log number, or a copy of a paper temporary or Presumptive Eligibility card).

❑ Nursing home level of care / liability amount changes.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 Health Care Claim Payment / Advice transaction number _____ R/S / check issue date _____ (R/S attached if available).
New level of care _____
New liability amount _____

❑ Retroactive recipient eligibility for Wisconsin Medicaid (attach appropriate documentation for retroactive period, if available).

❑ Retroactive eligibility for general relief.

❑ Other insurance / Medicare recoupment (recoupment dated _____ attached).

❑ Medicare denial or reconsideration (reconsideration date _____ attached).

❑ Medicaid reconsideration.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 Health Care Claim Payment / Advice transaction number _____ R/S / check issue date _____ (R/S attached if available).

❑ Fair hearing decision, with signature dated _____ (complete copy attached).

❑ Court order, with signature dated _____ (complete copy attached).

Briefly explain the nature of the problem and previous efforts made to resolve the claims.

To obtain retroactive rate increase for nursing home room and board (per *Update* 2004-57).

SIGNATURE — Provider	Date Signed
I M Hospice Provider	**MM/DD/YY**

Continued

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Claims Submission section of the All-Provider Handbook and the applicable service-specific handbook for service restrictions and additional documentation requirements.

Attach the completed Timely Filing Appeals Request to the claim or adjustment form and attachments and submit them to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Timely Filing
Ste 50
6406 Bridge Rd
Madison WI 53784-0050