

To:

Personal Care
Agencies

HMOs and Other
Managed Care
Programs

New UB-04 (CMS 1450) Claim Instructions for Personal Care Services

Wisconsin Medicaid will begin accepting the new UB-04 (CMS 1450) claim form for UB claims received on and after March 1, 2007. Wisconsin Medicaid will continue to accept the UB-92.

Wisconsin Medicaid will begin accepting the new UB-04 (CMS 1450) claim form for UB claims received on and after March 1, 2007.

Wisconsin Medicaid will continue to accept the UB-92; however, the National Uniform Billing Committee will supply only the new UB-04 claim form as of May 23, 2007.

New UB-04 Claim Form Completion Instructions

Providers should use the instructions in Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* when submitting UB-04 claim forms to Wisconsin Medicaid. Use these claim form completion instructions, not the form locator descriptions on the claim form, to avoid claim denial or inaccurate claim payment. Attachment 2 includes a sample UB-04 claim form.

Providers who are using the UB-92 claim form should continue to use their most recently published UB-92 claim form instructions.

Important Changes with the UB-04

Providers should note the following changes to the claim form completion instructions for the UB-04:

- Signature and date, indicated on the UB-92 in Form Locator 85, is not on the UB-04. Each provider is solely responsible for the truthfulness, accuracy, timeliness and completeness of claims relating to reimbursement for services submitted to Medicaid.
- The sum of all the charges on a claim is now indicated on Detail Line 23 in the field following the word “TOTALS.” Providers no longer indicate a claim’s total charge with revenue code “0001” in Form Locator 42 and the sum in Form Locator 47.

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

UB-04 (CMS 1450) Claim Form Instructions for Personal Care Services

(Effective for UB-04 Claims Received Beginning March 1, 2007)

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial 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-04 claim form for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 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 Recipient Eligibility section of the All-Provider Handbook or the Medicaid Web site at dhfs.wisconsin.gov/medicaid/ for more information about the EVS.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness and completeness of claims relating to reimbursement for services submitted to Medicaid.

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 57.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl. # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will be included in Medicaid remittance information.

Form Locator 3b — Med. Rec. # (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will be included in Medicaid remittance information.

Form Locator 4 — Type of Bill

Enter the three-digit type of bill code. Type of bill codes for personal care providers include the following:

- 331 = Admit through discharge claim.
- 332 = Interim — first claim.
- 333 = Interim — continuing claim.
- 334 = Interim — last claim.

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

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8a-b — Patient Name

Enter the recipient's last name and first name, separated by a space or comma, in Form Locator 8b. 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 9a-b — Patient Address

Enter the complete address of the recipient's place of residence.

Form Locator 10 — Birthdate

Enter the recipient's birth date in MMDDCCYY format (e.g., September 25, 1975 would be 09251975).

Form Locator 11 — Sex

Specify that the recipient is male with an "M" or female with an "F." If the recipient's sex is unknown, enter "U."

Form Locator 12 — Admission Date (not required)

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src (not required)

Form Locator 16 — DHr (not required)

Form Locator 17 — Stat (not required)

Form Locators 18-28 — Condition Codes (required, if applicable)

If appropriate, enter a code identifying a condition relating to this claim that may affect payer processing. Refer to the UB-04 Billing Manual for more information.

Form Locator 29 — Accident State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locator 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation, ancillary service, or billing calculation. Refer to personal care publications or the UB-04 Billing Manual for more information.

Form Locator 43 — Description

Enter the date of service (DOS) in the MMDDYY format either in this form locator or in Form Locator 45.

When series billing, (i.e., billing from two to four DOS on the same line), indicate the DOS in the following format: MMDDYY, MMDD, MMDD, MMDD. Indicate the dates in order of occurrence from the first to the last of the month.

Providers may enter up to four DOS for each revenue and procedure code if all of the following conditions are met:

- All DOS are in the same calendar month.
- All DOS are listed in order of occurrence from the first to the last of the month.
- All procedure codes are identical. All procedure modifiers are identical.
- All charges are identical.
- All quantities billed for each DOS are identical.

On paper claims, no more than 23 lines may be submitted on a single claim, including the “Total Charges” line.

Note: Wisconsin Medicaid encourages providers to enter only one DOS per line. Although series billing (entering multiple DOS on the same line) remains an option, providers may find that meeting the conditions limits the convenience of using this method.

Form Locator 44 — HCPCS/Rates/HIPPS Code

Enter the appropriate five-digit procedure code and the appropriate modifier. Refer to personal care publications for appropriate modifiers.

Form Locator 45 — Serv. Date

Enter the DOS in the MMDDYY format either in this form locator or in Form Locator 43. Do not indicate multiple DOS in this form locator. Multiple DOS are required to be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of units of service or visits where appropriate. For each DOS, indicate whole units rounded to the nearest 15 minutes (15 minutes = 1 unit). If billing multiple DOS on a single line, the time units indicated must be evenly divisible by the number of days indicated on the line. Refer to personal care publications for rounding guidelines.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locators 43 or 45.

Form Locator 48 — Non-covered Charges (not required)**Form Locator 49 — Unlabeled Field (not required)*****DETAIL LINE 23******PAGE ____ OF ____ (not required)***

Wisconsin Medicaid accepts only one-page claim forms.

CREATION DATE (not required)***TOTALS***

Enter the sum of all charges for the claim in this field.

Form Locator 50 A-C — Payer Name

Enter all health insurance payers here. Enter "T19" for Wisconsin Medicaid and/or the name of the commercial health insurance.

Form Locator 51 A-C — Health Plan ID (not required)**Form Locator 52 A-C — Rel Info (not required)****Form Locator 53 A-C — Asg Ben (not required)****Form Locator 54 A-C — 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 80.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C — Est Amount Due (not required)**Form Locator 56 — NPI (not required)****Form Locator 57 — Other Provider ID**

Enter the provider's Medicaid provider number. The provider number in Form Locator 57 should correspond with the name in Form Locator 1.

Form Locator 58 A-C — Insured’s Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured’s Unique ID

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), HCF 11018. 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. Do not attach the PA to the claim.

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — DX Version Qualifier (not required)

Form Locator 67 — Prin. Diag. Cd.

Enter the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (up to five digits) 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). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include “E” codes.

Form Locators 67A-Q — 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. Diagnoses which relate to an earlier episode have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx (not required)

Form Locator 70 — Patient Reason Dx (not required)

Form Locator 71 — PPS Code (not required)

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending (not required)

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other ID (not required)

Form Locator 80 — 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 80.

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 health insurance, *and* the service requires commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. 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 the following: <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.

Form Locator 81 — CC (not required)

ATTACHMENT 2

Sample UB-04 Claim Form for Personal Care Services

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|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| IM BILLING PROVIDER 321 ANYWHERE RD ANYTOWN WI 55555 (444) 444-4444 | | | | | | | | | | JED 1234 03 765432 STATEMENT COVERS PERIOD FROM THROUGH | | | | | | | | | | TYPE OF BILL 334 | | | | | | | | | | | |
| PATIENT NAME RECIPIENT, IM A | | | | | | | | | | PATIENT ADDRESS 555 ORBITING DRIVE, WESTHILL, WI 52345 | | | | | | | | | | | | | | | | | | | | | |
| BIRTHDATE 07151955 | | | | | | | | | | SEX F | | | | | | | | | | | | | | | | | | | | | |
| OCCURRENCE CODE 0570 | | | | | | | | | | OCCURRENCE DATE 0209 0211 0215 | | | | | | | | | | | | | | | | | | | | | |
| OCCURRENCE CODE 0570 | | | | | | | | | | OCCURRENCE DATE 0209 0211 0215 | | | | | | | | | | | | | | | | | | | | | |
| OCCURRENCE CODE 0550 | | | | | | | | | | OCCURRENCE DATE 021507 | | | | | | | | | | | | | | | | | | | | | |
| VALUE CODES AMOUNT T1019 16.0 T1019 U3 8.0 99509 TD 1.0 | | | | | | | | | | VALUE CODES AMOUNT XX XX XX XX XX XX | | | | | | | | | | | | | | | | | | | | | |
| REV CD 0570 0570 0550 | | | | | | | | | | DESCRIPTION 020107 0209 0211 0215 020107 0209 0211 0215 021507 | | | | | | | | | | HICHS - DATE / HICHS CODE T1019 T1019 U3 99509 TD | | | | | | | | | | TOTALS 16.0 8.0 1.0 XXX XX | |
| PROVIDER NAME XYZ INSURANCE T19 MEDICAID | | | | | | | | | | HEALTH PLAN ID 87654321 | | | | | | | | | | | | | | | | | | | | | |
| INSURED'S NAME 1234567890 | | | | | | | | | | INSURED'S UNIQUE ID 1234567890 | | | | | | | | | | | | | | | | | | | | | |
| TREATMENT AUTHORIZATION CODES 1234567 | | | | | | | | | | DOCUMENT CONTROL NUMBER 5750 | | | | | | | | | | | | | | | | | | | | | |
| ADMIT DM 14 | | | | | | | | | | SURVIVANT REASON TO 15 | | | | | | | | | | | | | | | | | | | | | |
| OTHER PROCEDURE CODE 16 | | | | | | | | | | OTHER PROCEDURE DATE 17 | | | | | | | | | | | | | | | | | | | | | |
| OTHER PROCEDURE CODE 18 | | | | | | | | | | OTHER PROCEDURE DATE 19 | | | | | | | | | | | | | | | | | | | | | |
| OTHER PROCEDURE CODE 20 | | | | | | | | | | OTHER PROCEDURE DATE 21 | | | | | | | | | | | | | | | | | | | | | |
| REMARKS OI-D | | | | | | | | | | ATTENDING NP LAST FIRST 22 | | | | | | | | | | | | | | | | | | | | | |
| REMARKS OI-D | | | | | | | | | | OPERATING NP LAST FIRST 23 | | | | | | | | | | | | | | | | | | | | | |
| REMARKS OI-D | | | | | | | | | | OTHER NP LAST FIRST 24 | | | | | | | | | | | | | | | | | | | | | |
| REMARKS OI-D | | | | | | | | | | OTHER NP LAST FIRST 25 | | | | | | | | | | | | | | | | | | | | | |