Wisconsin Medicaid and BadgerCare update

February 2007 ● No. 2007-21

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Hospice Providers

HMOs and Other Managed Care Programs

New UB-04 (CMS 1450) Claim Instructions for Hospice 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.
- For Form Locator 76 on the UB-04, the biller is required to indicate a provider identification qualifier (refer to Attachment 1) before indicating the provider's identification number. The qualifier identifies the type of identification number being indicated (e.g., a Medicaid provider number, a license number).

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 Hospice 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. # (not required)

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. The first digit identifies the type of facility. The second digit classifies the type of care. Hospice providers should use bill types 81X (non-hospital-based hospice) or 82X (hospital-based hospice). The third digit ("X") indicates the billing frequency, and providers should enter one of the following for "X":

- 1 = Admit through discharge claim.
- 2 = Interim — first claim.
- 3 = Interim — continuing claim.
- 4 = Interim — final 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 (not required)

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 (not required)

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)

Enter the code(s) identifying a condition related to this claim, if appropriate. 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 the 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 (required, if applicable)

Enter the relevant value code and associated amount, if applicable. Refer to the UB-04 Billing Manual for more information on value codes.

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to hospice publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description

Enter the date of service (DOS) billed in MMDDYY in Form Locator 43 or 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 code if all of the following conditions are met:

- All DOS are in the same calendar month.
- All services performed are identical.
- All services were performed by the same provider.
- The number of units indicated in Form Locator 46 is divisible by the number of DOS.

If it is necessary to indicate more than four DOS per revenue code, indicate the dates on the subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim, including the "Total Charges" line. Do *not* include the date of discharge or death.

Form Locator 44 — HCPCS/Rates/HIPPS Code (not required)

Form Locator 45 — Serv. Date

Enter the DOS in MMDDYY format in the form locator or Form Locator 43. Multiple DOS must be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of covered accommodations days or ancillary units of service for each line item. Units are measured in days for revenue codes "0169," "0651," "0655," and "0656," and in hours for revenue code "0652."

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

Enter the usual and customary charges for each line item.

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

Enter the dollar amount of any patient liability.

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 (not required)

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 that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and that 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

To indicate the attending provider, enter a provider identification qualifier in the first field to the right of "Qual" and the identification number itself in the second field to the right of "Qual." In addition, include the last and first name of the attending provider. Providers may use one of the following provider identification qualifiers:

- 0B — State license number.
- 1D — Medicaid provider number.
- 1G — Universal Provider Identification Number (UPIN).

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: ✓ 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 80 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 must be Medicare certified to perform Medicare-covered services for dual eligibles.
- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

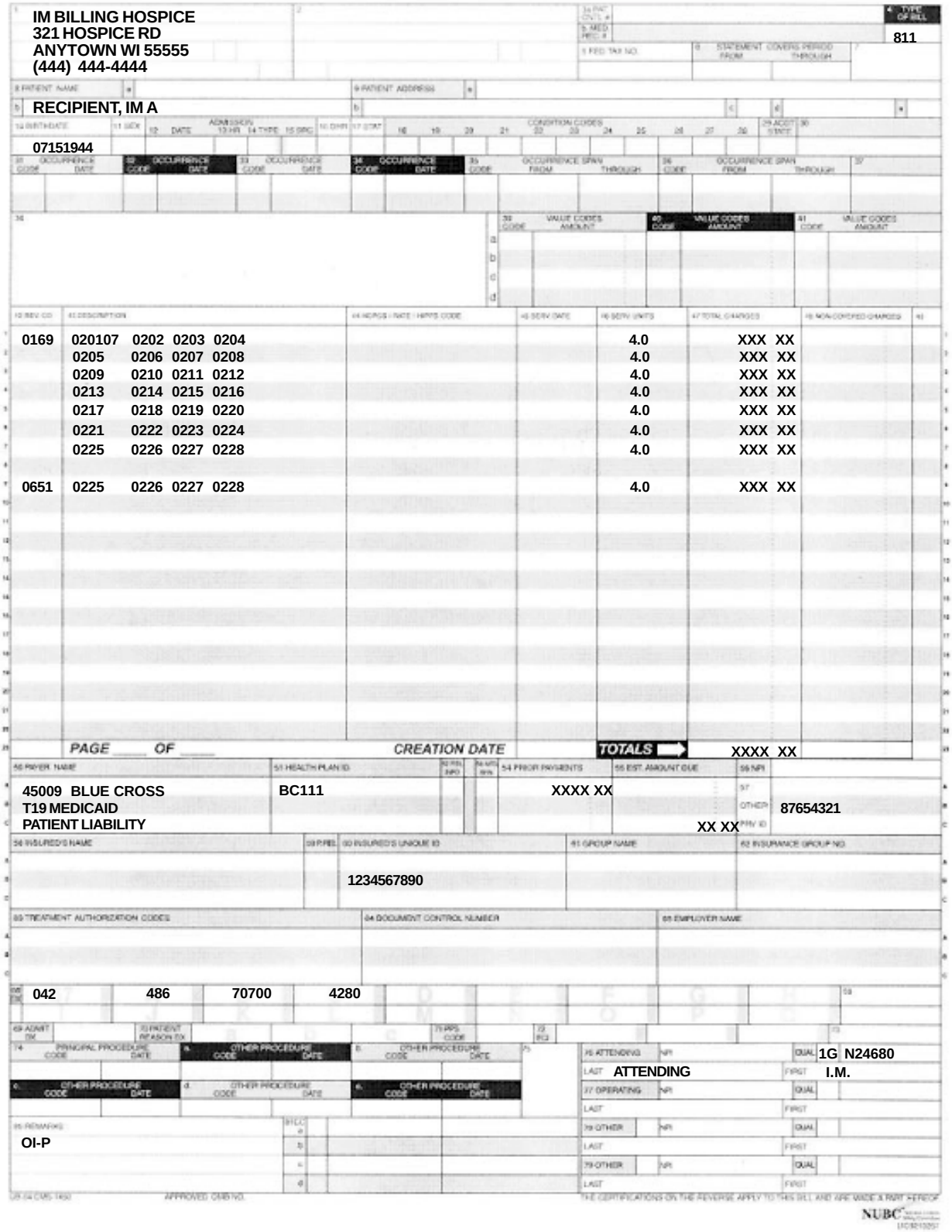
If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-5	**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 DOS before or after their Medicare certification effective dates. *For Medicare Part A, use M-5 in the following instances (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B, use M-5 in the following instances (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B, use M-8 in the following instances (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Form Locator 81 — CC (not required)

ATTACHMENT 2
Sample UB-04 Claim Form for Hospice Services

This is a sample claim for a recipient who resides in a nursing home and subsequently enrolls in hospice care.



IM BILLING HOSPICE
321 HOSPICE RD
ANYTOWN WI 55555
(444) 444-4444

4 TYPE OF BILL: 811

a RECIPIENT, IM A

12 BIRTHDATE: 07151944

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0169	020107 0202 0203 0204			4.0	XXX XX	
	0205 0206 0207 0208			4.0	XXX XX	
	0209 0210 0211 0212			4.0	XXX XX	
	0213 0214 0215 0216			4.0	XXX XX	
	0217 0218 0219 0220			4.0	XXX XX	
	0221 0222 0223 0224			4.0	XXX XX	
	0225 0226 0227 0228			4.0	XXX XX	
0651	0225 0226 0227 0228			4.0	XXX XX	
	PAGE ____ OF ____	CREATION DATE		TOTALS	XXXX XX	

50 PAYER NAME: 45009 BLUE CROSS / T19 MEDICAID / PATIENT LIABILITY
51 HEALTH PLAN ID: BC111
54 PRIOR PAYMENTS: XXXX XX
56 NPI
57 OTHER PRV ID: 87654321
55 EST. AMOUNT DUE: XX XX

60 INSURED'S UNIQUE ID: 1234567890

66 DX: 042 | 486 | 70700 | 4280

76 ATTENDING NPI: QUAL 1G N24680
LAST ATTENDING FIRST I.M.

19 REMARKS: OI-P

NUBC