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# WISCONSIN MEDICAID UPDATE

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MARCH 12, 1996

UPDATE 96-03

TO:

Case Management Providers  
County Departments of:

Community Programs

Human Services

Social Services

County/Tribal Aging Units

Family Planning Clinics

HealthCheck Screeners

Home Health Agencies

Hospitals

Independent Laboratories

Local Health Departments

Nurse Midwives

Nurse Practitioners

Nurses in Independent Practice

Personal Care Agencies

Pharmacies

Physician Assistants

Physicians

Prenatal Care Coordination Providers

Rural Health Clinics

SMV Providers

## New Tuberculosis (TB) Benefit

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### Wisconsin Medicaid Covers New Group of Individuals for TB-related Services

Wisconsin Act 27, Laws of 1995, the biennial budget, expands eligibility for Wisconsin Medicaid to cover individuals infected with tuberculosis (TB) or who have active disease and who meet financial eligibility requirements. This is effective for dates of service on and after July 29, 1995. This was included in the biennial budget as an effort to combat an increased incidence of TB.

This group of individuals is eligible for Medicaid-covered TB-related services only. (This group is referred to as "TR recipients" in the rest of this *Update*.)

TR recipients receive a blue Medicaid card. The medical status on the card is "TR." At the bottom of the card, the message reads:  
"Limited Services.  
Call EDS Voice Response"

The following outpatient TB-related services only are covered for TR recipients:

1. Current Medicaid-covered services:

- *TB-related drugs* - (the drugs listed in Attachment 2 are considered TB-related. Coverage of other drugs may be TB-related if verified with the prescriber)

- *physician and clinic services*
- *laboratory and x-ray services - including services to diagnose and confirm TB infection*
- *transportation services*

2. New Medicaid-covered services:

- *case management services - services to help a recipient and, when appropriate, the recipient's family gain access to, coordinate, or monitor necessary medical, social, educational, vocational and other services (this is available to recipients enrolled in HMOs beginning July 1, 1996, subject to guidelines which will be sent to case management providers and to HMOs before July)*
- *directly observed therapy (DOT) and directly observed preventive therapy (DOPT) - direct observation by a health care provider or other designated person as the patient ingests the TB medication*
- *TB symptom and treatment monitoring - clinical assessment of TB, including history of treatment for TB infection or disease, monitoring adherence to the prescribed regimen, signs and symptoms of disease, and adverse reactions*
- *patient education and anticipatory guidance - provision of information about TB infection or disease, diagnostic tests, treatment, benefits of adherence to treatment, and follow-up care*

You may immediately submit claims for TR recipients. For more information, see the following attachments:

*Attachment 1 - Eligibility Information*

*Attachment 2 - Covered Services and Noncovered Services Information*

*Attachment 4 - General Billing Information*

*Attachment 5 - Frequently Billed TB-related Procedure Codes*

*Attachments 6, 7 & 8 - HCFA 1500 & UB-92 Instructions and Sample*

## **Wisconsin Medicaid Adds New TB-related Services for All Recipients with a TB Diagnosis**

The biennial budget also added the new TB-related services for all Medicaid recipients who are infected with TB or have active disease. Recipients enrolled in Medicaid HMOs are also eligible for the new services on a fee-for-service basis (other services must be provided through the HMO).

These new services are the same as those covered for TR recipients. They are:

- *case management services (this is available to recipients enrolled in HMOs beginning July 1, 1996, subject to guidelines which will be sent to case management providers and to HMOs in the near future)*
- *directly observed therapy (DOT) and directly observed preventive therapy (DOPT)*
- *TB symptom and treatment monitoring*
- *patient education and anticipatory guidance*

For information about these services, see Attachment 3. For billing information, claim form samples and instructions, see Attachments 4, 5, 6, 7 & 8.

## What To Do If You Are Interested in Providing TB-related Services

### If You Are *Currently* Certified with Wisconsin Medicaid

If you are currently certified with Wisconsin Medicaid, follow the guidelines and instructions given in this *Update* and Attachments 1 through 8.

Also, if you are a certified case management provider, you must elect the new target population persons with TB. Refer to Appendix 4 in the case management handbook (Part U).

### If You Are *Not* Certified with Wisconsin Medicaid

If you are not currently certified with Wisconsin Medicaid, do the following:

1. Check the list in Attachment 2 and see if you are eligible to become a provider who can provide the specific service.
2. If you are eligible to become a provider as specified in Attachment 2, ask for a certification packet by writing or calling:

#### EDS

Attn: Provider Maintenance  
6406 Bridge Road  
Madison, WI 53784-0006  
(800) 947-9627 or (608) 221-9883

3. Complete the certification packet. You have 30 days from the date on the application cover letter to complete and *return* the certification packet if you want your certification backdated to July 29, 1995.
4. After you become certified, follow the instructions given in this *Update* and all other publications.

## You May Be Reimbursed for Services You Provided Since July 29, 1995

Since the TB benefit became effective July 29, 1995, some individuals may have their eligibility backdated to this date. As a result, you may submit claims for services provided on and after July 29, 1995.

Since eligibility dates vary for each recipient, check the recipient's Medicaid identification card or call Voice Response to get the dates for which the recipient is eligible to receive TB-related services. See Section IV in Part A, the all-provider handbook, for more information.

## Reimbursement for Covered TB-related Services

Reimbursement for all covered TB-related services is at the lesser of the usual and customary fee or the maximum allowable fee.

The current maximum allowable fee for the *new services* (W6271-W6276) is \$35.00 per hour.

Recipients eligible for Medicaid TB-related services are not eligible for the State of Wisconsin's DOT/DOPT Reimbursement Program.

Home health agencies, nurses in independent practice, and personal care agencies can only bill TB-related services for persons who meet the requirements in this *Update*. Do not bill procedure codes W6271 and W6276 at the same time you bill procedure codes for home health, private duty nursing and personal care, including supervisory visits.

The relevant procedure codes for home health, private duty nursing, and personal care, including supervisory visits, are: W9925, W9930, W9932, W9940, W9931, W9941, W9030, W9031, W9045, W9046,

W9041, W9042, W9964, W9965, W9966, W9967, W9968, W9969, W9990, W9902, W9903, W9906, W9044.

Medicaid payments are subject to recoupment if both services are billed for the same service date and time. You must bill the service as either a currently covered service (home health, private duty nursing, and personal care) or as a new TB-related service. In other words, providers cannot bill the same service twice.

The *new services* (W6271-W6276) are not counted as part of the Home Care Cap.

## **Reminder about TB Reporting Requirements**

### **Active TB Disease Reporting**

According to HSS 145.04 (1-4), Wis. Admin. Code, you must report any suspect or confirmed case of active TB to your local health department and the state TB program, regardless of how treatment is being reimbursed.

You need to provide the information requested on the 4151 form ("Acute and Communicable Diseases Case Report Form").

To request the Acute and Communicable Diseases Case Report Form (Form 4151), write or call:

Pam Hazlett  
Wisconsin Division of Health  
Communicable Disease Section  
Room 241  
1414 E. Washington Avenue  
Madison, WI 43703  
(608) 267-7321

### **TB Infected Reporting**

There is no mandatory state reporting requirement for individuals who are TB-infected only. However, there may be local reporting requirements. Contact your local health department for any local reporting requirements.

## TR Recipients Eligibility Information

### What Are the Eligibility Requirements?

#### Individuals Must Have a Documented TB Infection or Disease

##### *TB Infection or Disease Criteria*

The individual must either be TB-infected or have active TB disease and meet one of the following criteria:

- ① the individual is infected with latent or active TB
- ② the individual has a TB positive tuberculin skin test
- ③ the individual has a negative tuberculin skin test, but a positive sputum culture
- ④ the individual tests negative for TB, but based on a physician's judgement, requires TB-related drug and/or surgical therapy
- ⑤ based on a physician's judgement, the individual requires testing to confirm the presence (or absence) of the TB organism

TB infection includes the criteria listed in 1, 2, 4, or 5. Active TB disease includes the criteria listed in 1, 2, 3, 4, or 5.

##### *TB Infection or Disease Must Have Written Verification*

The individual must have written verification of TB infection or disease

provided by a local health department, physician or registered nurse.

Written verification *must* include the date that the TB infection or active disease was established, since the date is used to establish eligibility for the TB benefit. Eligible individuals may have their eligibility backdated up to a three-month period after this initial backdating period.

The written verification must be in one of the following forms:

- ① a completed TB information card that shows:
  - the individual's name
  - whether the individual is infected with TB or has active disease
  - the date this TB status (infected with TB or has active disease) was established
  - the treatment provider's name and phone number

To request the TB information card (DOH #4756), write to: Wisconsin DHSS Forms Center, P. O. Box 309, Madison, WI 53701. Include the number "DOH #4756" when requesting the form.

- ② or a written note from a physician or registered nurse that includes the same information as the TB information card

## Individuals Must Meet Financial Eligibility Requirements

The financial eligibility requirements are:

- ✓ an income of no more than \$1,001 per month
- ✓ assets of no more than \$2,000

### How Do Individuals Apply for the TB Benefit?

Enrollment for the TB benefit varies by county. In some counties, individuals may enroll with the county or tribal social services agency. In other counties, individuals may enroll with the local health department.

For more information, individuals may contact one of the following:

- the county social services department (human services department in those counties that do not have a social services department)
- the tribal social services agency
- the local health department

### How Do Providers Verify Recipient Eligibility?

Recipients eligible for the TB-related services only benefit are given the medical status code "TR". These recipients receive a regular blue Medicaid card with a new message on the bottom of the card: "Limited Services. Call EDS Voice Response". (Status code TR does appear on the card.) The card also shows the retroactive eligibility date from which the recipient is eligible to receive TB-related services.

Call Voice Response at (800) 947-9627 or (608) 221-9883. Voice response will give you eligibility information for the individual.

## Attachment 2

### TR Recipients Covered and Noncovered Services Information

#### What Services Are Covered for TR Recipients?

The new benefit is designed to cover outpatient TB-related services. The chart shows the covered outpatient TB-related services that are reimbursable when provided to TR recipients. In addition, the chart shows the allowable providers who may be reimbursed for providing the specific services.

The covered services must relate to the treatment or complications of TB and vary depending on individual's circumstances. For example, services necessary because of side effects of drugs prescribed to treat TB may be covered as TB-related services.

#### What Services Are Not Covered for TR Recipients?

##### **Inpatient Hospital and Nursing Home Services Are Not Covered**

Inpatient hospital services and nursing home services are not covered for TR recipients. The new benefit is designed to cover outpatient TB-related services only.

##### **Services Unrelated to TB Are Not Covered**

Services unrelated to the treatment or complications of TB are not covered for TR recipients. For example, routine dental services and alcohol and other drug abuse (AODA) day treatment services are not covered.

**Attachment 2 (continued)**

<b>Covered Services for TR Recipients</b>	
<b>Covered Services</b>	<b>Allowable Providers</b>
<p><b>Prescribed drugs</b> - TB-related drugs include:</p> <p>Isoniazid  Rifampin - Rifadin®, Rimactane®  Rifabutin - Mycobutin®  Ethambutol - Myambutol®  Pyrazinamide  Streptomycin  - P-aminosalicylic acid - Sodium P.A.S.®  Ethionamide - Trecator-SC®  Cycloserine - Seromycin®  Capreomycin - Capastat®  Kanamycin - Kantrex®  Pyridoxine  Rifamate®  Rimactane/INH Dual Pack®  Rifater®</p> <p>Coverage of other drugs may be TB-related if verified with the prescriber.  <i>(Vitamin B6: Effective for dates of service on and after January 1, 1996, pyridoxine tablets (10, 25, 50 and 100 mg.)--Vitamin B<sub>6</sub>-- are covered as over-the-counter (OTC) medication.)</i></p>	<ul style="list-style-type: none"> <li>• pharmacies</li> <li>• physicians and physician clinics</li> </ul>
<p><b>Physician and Clinic services</b>, including office visits</p>	<ul style="list-style-type: none"> <li>• physicians and physician clinics</li> <li>• the following providers within their scope of practice: <ul style="list-style-type: none"> <li>family planning clinics</li> <li>nurses in independent practice</li> <li>nurse midwives</li> <li>nurse practitioners</li> <li>physician assistants</li> <li>rural health clinics</li> </ul> </li> </ul>
<p><b>Laboratory services</b>, including services to diagnose and confirm the presence of infection</p> <p>These services are intended to include services to diagnose and confirm the presence of the infection. Since some individuals may not be determined Medicaid-eligible until the infection is confirmed, TR recipients may request that eligibility be retroactive to the date that the infection is confirmed.</p>	<ul style="list-style-type: none"> <li>• family planning clinics</li> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• independent laboratories</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination (PNCC) providers (including local health departments certified as PNCC providers)</li> <li>• rural health clinics</li> </ul>



**Attachment 2 (continued)**

<b>Covered Services for TR Recipients</b>	
<b>Covered Services</b>	<b>Allowable Providers</b>
<p><b>X-ray services</b>, including services to diagnose and confirm the presence of infection</p> <p>These services are intended to include services to diagnose and confirm the presence of the infection. Since some individuals may not be determined Medicaid-eligible until the infection is confirmed, TR recipients may request that eligibility be retroactive to the date that the infection is confirmed.</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• family planning clinics</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• physicians and physician clinics</li> <li>• physician assistants</li> <li>• portable x-ray providers</li> <li>• prenatal care coordination (PNCC) providers (including local health departments certified as PNCC providers)</li> </ul>
<p><b>Case Management services</b> - Services to help a recipient and, when appropriate, the recipient's family gain access to, coordinate, or monitor necessary medical, social, educational, vocational and other services.</p> <p>All case management services must include the new target group: individuals infected with TB. The target group codes are: 44A-TB, non-COP or 44B-TB, COP.</p> <p>(HMO recipients will be eligible for case management services on a fee-for-service basis starting July 1, 1996, subject to guidelines which will be sent to case management providers and to HMOs before July.)</p>	<ul style="list-style-type: none"> <li>• case management providers (case management services are available from or through certified case management providers in counties, cities, villages or towns that elect to pay the portion of costs not covered by the federal government)</li> </ul>
<p><b>Transportation</b> - Common carrier is provided at the county level and is covered for TR recipients in the same manner as it is for other Medicaid recipients. TR recipients are eligible for Specialized Medical Vehicle (SMV) transportation if they meet the SMV criteria. If they do not meet the SMV criteria, they are eligible for common carrier transportation. The recipient or the recipient's case manager must contact the county social services agency to arrange common carrier transportation.</p>	<ul style="list-style-type: none"> <li>• county/tribal social service agency (for common carrier transportation)</li> </ul> <p>Common carrier transportation of contagious individuals is handled on a "case by case" basis by the recipient's case manager and the county social services agency.</p> <ul style="list-style-type: none"> <li>• specialized medical vehicle (SMV) providers</li> </ul>

**Attachment 2 (continued)**

<b>Covered Services for TR Recipients</b>	
<b>Covered Services</b>	<b>Allowable Providers</b>
<p><b>Directly Observed Therapy (DOT) and Directly Observed Preventive Therapy (DOPT) (new service)</b> - Direct observation by a health care provider or other designated person as the patient ingests the TB medication.</p> <p>Reimbursement for DOT/DOPT includes: necessary travel time and the delivery of medications (if free delivery is unavailable).</p> <p>Use the appropriate code to bill for DOPT: W6271 TB (Infected Only/No Disease), or DOT: W6274 (Suspect or Confirmed Active TB Disease Case).</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• home health agencies</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• personal care providers</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination providers (including local health departments certified as PNCC providers)</li> <li>• rural health clinics</li> </ul>
<p><b>TB Symptom and Treatment Monitoring (new service)</b> - Clinical assessment of TB, including history of treatment for TB infection or disease, monitoring adherence to the prescribed regimen, signs and symptoms of disease, and adverse reactions.</p> <p>Reimbursement for TB Symptom and Treatment Monitoring includes necessary travel time.</p> <p>Use the appropriate code to bill: W6272 (TB Infected Only/No Disease) or W6275 (Suspect or Confirmed Active TB Disease Case).</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• home health agencies</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination (PNCC) providers (including local health departments certified as PNCC providers)</li> <li>• rural health clinics</li> </ul>
<p><b>Patient Education and Anticipatory Guidance - (new service)</b> providing information about TB infection or disease, diagnostic tests, treatment, benefits of adherence to treatment, and follow up care.</p> <p>Reimbursement for Patient Education and Anticipatory Guidance includes any needed interpreter services and travel time.</p> <p>Use the appropriate code to bill: W6273 (TB Infected Only/No Disease) or W6276 (Suspect or Confirmed Active TB Disease).</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• home health agencies</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination (PNCC) providers</li> <li>• rural health clinics</li> </ul>

### Attachment 3

## New Services for All Recipients with TB

This list is repeated from Attachment 2 for easy reference. These new services are available to TR recipients and to all other recipients with TB.

<b>New Services for Recipients with TB</b>	
<b>Covered Services</b>	<b>Allowable Providers</b>
<p><b>Case Management services</b> - Services to help a recipient and, when appropriate, the recipient's family gain access to, coordinate, or monitor necessary medical, social, educational, vocational and other services.</p> <p>All case management services must include the new target group TB persons. The target group codes are: 44A-TB, non-COP or 44B-TB, COP.</p> <p>(HMO recipients will be eligible for case management services on a fee-for-service basis starting July 1, 1996, subject to guidelines which will be sent to case management providers and to HMOs before July.)</p>	<ul style="list-style-type: none"> <li>• case management providers (case management services are available from or through certified case management providers in counties, cities, villages or towns that elect to pay the portion of costs not covered by the federal government)</li> </ul>
<p><b>Directly Observed Therapy (DOT) and Directly Observed Preventive Therapy (DOPT)</b> - Direct observation by a health care provider or other designated person as the patient ingests the TB medication.</p> <p>Reimbursement for DOT/DOPT includes: necessary travel time and the delivery of medications (if free delivery is unavailable).</p> <p>Use the appropriate code to bill for DOPT: W6271 (TB Infected Only/No Disease), or DOT: W6274 (Suspect or Confirmed Active TB Disease Case).</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• home health agencies</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• personal care providers</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination providers (including local health departments certified as PNCC providers)</li> <li>• rural health clinics</li> </ul>
<p><b>TB Symptom and Treatment Monitoring</b> - Clinical assessment of TB, including history of treatment for TB infection or disease, monitoring adherence to the prescribed regimen, signs and symptoms of disease, and adverse reactions.</p> <p>Reimbursement for TB Symptom and Treatment Monitoring includes necessary travel time.</p> <p>Use the appropriate code to bill: W6272 (TB Infected Only/No Disease) or W6275 (Suspect or Confirmed Active TB Disease Case).</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• home health agencies</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination (PNCC) providers (including local health departments certified as PNCC providers)</li> <li>• rural health clinics</li> </ul>

**Attachment 3 (continued)**

<b>New Services for Recipients with TB</b>	
<b>Covered Services</b>	<b>Allowable Providers</b>
<p><b>Patient Education and Anticipatory Guidance</b> - providing information about TB infection or disease, diagnostic tests, treatment, benefits of adherence to treatment, and follow up care.</p> <p>Reimbursement for Patient Education and Anticipatory Guidance includes any needed interpreter services and travel time.</p> <p>Use the appropriate code to bill: W6273 (TB Infected Only/No Disease) or W6276 (Suspect or Confirmed Active TB Disease).</p>	<ul style="list-style-type: none"> <li>• HealthCheck screeners (including local health departments certified as screeners)</li> <li>• home health agencies</li> <li>• nurses in independent practice</li> <li>• nurse midwives</li> <li>• nurse practitioners</li> <li>• outpatient hospitals</li> <li>• physician assistants</li> <li>• physicians and physician clinics</li> <li>• prenatal care coordination (PNCC) providers</li> <li>• rural health clinics</li> </ul>

Attachment 4

General Billing Information for All TB-related Services

Follow the same billing instructions given in the specific service publications (i.e., if you are a physician, review the physician handbook and updates) as for all other Medicaid recipients.

In addition, do the following:

1. Except for independent laboratories, portable x-ray providers, and pharmacies, always enter one of the ICD-9-CM TB diagnosis codes on the claim form when providing services for TR recipients. (See the list of TB diagnosis codes.)
2. If billing for one of the new services (case management, DOT and DOPT, TB symptom and treatment monitoring, or patient education and anticipatory guidance) for TR recipients and all other recipients with TB:
  - Always enter one of the TB diagnosis codes on the claim form (see the list of TB diagnosis codes).
  - It would be easier for you to bill monthly. Accumulate the time you spend providing these services on a monthly basis and round to the nearest tenth of an hour (see the chart for rounding guidelines).
  - *Don't* charge a copayment. There are no copayments for these new services.

ICD-9-CM Diagnosis Codes	
V01.1	Contact with or exposure to TB
V71.2	Observation for suspected TB
V72.5	Radiological examination, not elsewhere classified
V74.1	Special screening examination for pulmonary TB
010-018.9	TB
137-137.4	Late effects of TB
771.2	Congenital TB
795.5	Nonspecific reaction to TB skin test without active TB

Rounding Guidelines. . .	
<u>Time (in Minutes)</u>	<u>Units Billed</u>
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0

**Attachment 5**

**Typical TB-related Procedure Codes for All Recipients with TB**

The following chart shows typical TB-related procedure codes for the HCFA 1500 claim form. It also shows the allowable place of service (POS) and type of service (TOS) codes, and an indication of whether or not Medicare covers the service. Check your provider handbook to verify other allowable procedures, along with their allowable TOS and POS codes.

<b>Procedure Code</b>	<b>Place of Service*</b>	<b>Type of Service**</b>	<b>Medicare Covered</b>
<b>New Services - Local Codes</b>			
W6271 - Directly Observed Preventive Therapy (DOPT) - TB Infected Only	0, 2, 3, 4	1	NO
W6272 - TB Symptom and Treatment Monitoring TB Infected Only	0, 2, 3, 4	1	NO
W6273 - Patient Education and Anticipatory Guidance - TB Infected Only	0, 2, 3, 4	1	NO
W6274 - Directly Observed Therapy (DOT) - Suspect or Confirmed Active Case	0, 2, 3, 4	1	NO
W6275 - TB Symptom and Treatment Monitoring- Suspect or Confirmed Active Case	0, 2, 3, 4	1	NO
W6276 - Patient Education and Anticipatory Guidance - Suspect or Confirmed Active Case	0, 2, 3, 4	1	NO
<b>Lab, X-ray and Diagnostic Services - CPT Codes</b>			
71010 - Chest X-ray, Interpretation, One View	0, 2, 3	Q	YES
71020 - Chest X-ray, Interpretation, Two Views	0, 2, 3	Q	YES
71010 - Chest X-ray, Total Charge, One View	0, 3	4	YES
71020 - Chest X-ray, Total Charge, Two Views	0, 3	4	YES
86580 - Skin Test; TB	0, 3	5	YES
89350 - Sputum, Obtaining Specimen	0, 3	5	YES
94664 - Aerosol or Vapor Inhalations for Sputum Mobilization	0, 2, 3	1	YES

**Attachment 5 (continued)**

<b>Procedure Code</b>	<b>Place of Service*</b>	<b>Type of Service**</b>	<b>Medicare Covered</b>
94665 - Aerosol or Vapor Inhalations for Sputum Mobilization Bronchodilation or Sputum Induction	0, 2, 3	1	YES
99000 - Lab Handling Fee	3	5	YES

\*Place of Service codes are:

- 0 - Other
- 2 - Outpatient Hospital
- 3 - Office
- 4 - Home

\*\*Type of Service codes are:

- 1 - Medical
- 4 - Diagnostic X-ray (total charge)
- 5 - Laboratory
- Q - Diagnostic X-ray (professional component only)

## Attachment 6

### HCFA 1500 Billing Instructions for TB-related Services

#### Element 1 - Program Block/Claim Sort Indicator

Enter your regular claim sort indicator, P.

#### Element 1a - Insured's ID Number

Enter the recipient's 10-digit Wisconsin Medicaid identification number as found on the current Medicaid identification card.

#### Element 2 - Patient's Name

Enter the recipient's last name, first name, and middle initial exactly as it appears on the current Medicaid identification card.

#### Element 3 - Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) exactly as it appears on the Medicaid identification card. Specify male or female with an "X".

#### Element 4 - Insured's Name (not required)

#### Element 5 - Patient's Address

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

#### Element 6 - Patient Relationship to Insured (not required)

#### Element 7 - Insured's Address (not required)

#### Element 8 - Patient Status (not required)

#### Element 9 - Other Insured's Name

Health insurance must be billed prior to billing Wisconsin Medicaid, unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

- When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medicaid identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook, or if the recipient's Medicaid identification card indicates "DEN" only, this element must be left blank.
- When "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes must be indicated in the *first* box of element 9. The description is not required, nor is the



## Attachment 6 (continued)

policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

### Code    Description

- OI-P    PAID by health insurance. The amount paid by health insurance to the provider or the insured is indicated on the claim.
- OI-D    DENIED by health insurance 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 in question was actually billed to and denied by the health insurer.
- OI-Y    YES, card indicates other coverage but it was not billed for reasons including, but not limited to:
- Recipient denies coverage or will not cooperate;
  - The provider knows the service in question is noncovered by the carrier;
  - Health insurance failed to respond to initial and follow-up claim; or
  - Benefits not assignable or cannot get an assignment.
- When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

### Code    Description

- OI-P    Paid by HMO or HMP. The amount paid is indicated on the claim.
- OI-H    HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

**Important Note:** The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

**Element 10 - Is Patient's Condition Related To** (not required)

### **Element 11 - Insured's Policy, Group or FECA Number**

The *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c and 11d are not required.) Medicare must be billed for covered services before billing Wisconsin Medicaid. When the recipient's Wisconsin Medicaid card indicates Medicare coverage, but Medicare does not allow any charges, one of the following

## Attachment 6 (continued)

Medicare disclaimer codes MUST be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed or denied payment
M-8	Noncovered Medicare service

If a recipient's Medicaid identification card indicates no Medicare coverage, this element may be left blank. If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A, the all-provider handbook for further information regarding submission of this type of claim. Refer to the attached table to determine which procedures are Medicare (T-18) covered.

### **Elements 12 and 13 - Authorized Person's Signature**

(Not required since the provider automatically accepts assignment through Medicaid certification.)

**Element 14 - Date of Current Illness, Injury, or Pregnancy** (not required)

**Element 15 - If Patient Has Had Same or Similar Illness** (not required)

**Element 16 - Dates Patient Unable to Work in Current Occupation** (not required)

**Element 17 - Name of Referring Physician or Other Source** (required if any lab services are performed, including a TB skin test)

**Element 17a - ID Number of Referring Physician** (required if any lab services are performed, including a TB skin test)

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

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

### **Element 20 - Outside Lab**

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

### **Element 21 - Diagnosis or Nature of Illness or Injury**

*The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM)* diagnosis code must be entered for each symptom or condition related to the services provided. See the body of this *Update* for a list of TB-related diagnoses. The diagnosis description is not required.

**Element 22 - Medicaid Resubmission** (not required)

## Attachment 6 (continued)

### Element 23 - Prior Authorization (not required)

#### Element 24a - Date(s) of Service

Enter the month, day, and year in MM/DD/YY format for each procedure.

For procedure codes in the W6271 - W6276 range, if the service was performed on more than one date during the month, indicate the last date the service was performed in each month as the date of service on the claim form. If you are billing for the service for more than one month, use a separate claim line (detail) for each month, determining the date of service as described here.

#### Element 24b - Place of Service

Enter the appropriate Wisconsin Medicaid single digit place of service code for each service. This is where the service took place. See the attached table for a list of allowable place of service codes.

#### Element 24c - Type of Service Code

Enter the appropriate type of service code. See the attached table for a list of allowable type of service codes.

#### Element 24d - Procedures, Services or Supplies

Enter the appropriate five-character procedure code. See the attached table for a list of allowable procedure codes.

#### Element 24e - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

#### Element 24f - Charges

Enter the total charge for each line.

#### Element 24g - Days or Units

Enter the total number of hours billed on each line, rounding to the nearest tenth of an hour. See Rounding Guidelines table for additional information.

#### Element 24h - EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

#### Element 24i - EMG

Enter an "E" for each procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

#### Element 24j - COB (not required)

#### Element 24k - Reserved for Local Use (not required)

## Attachment 6 (continued)

**Element 25 - Federal Tax ID Number** (not required)

**Element 26 - Patient's Account No.**

Optional - provider may enter up to 12 alphanumeric characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

**Element 27 - Accept Assignment**

(Not required, provider automatically accepts assignment through Medicaid certification.)

**Element 28 - Total Charge**

Enter the total charges for this claim.

**Element 29 - Amount Paid** (not required)

**Element 30 - Balance Due**

Enter the balance due as determined by subtracting the amount paid in element 29 from the amount in element 28.

**Element 31 - Signature of Physician or Supplier**

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

**Note:** This may be a computer-printed or typed name and date, or a signature stamp with the date.

**Element 32 - Name and Address of Facility Where Services Rendered**

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medicaid provider number.

**Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.

# Attachment 7 TB Services - HCFA 1500 Sample

APPROVED CMS 0028-0008

**HEALTH INSURANCE CLAIM FORM**

PCIA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SBN or ID) <input type="checkbox"/> FECA (BLK LINO (SBN) <input type="checkbox"/> OTHER <input type="checkbox"/>		10. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A.</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>MM XX YY</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No. Street) <b>609 Willow St.</b>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <b>Anytown</b> STATE <b>WI</b>		7. INSURED'S ADDRESS (No., Street) CITY STATE	
ZIP CODE <b>55555</b> TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT PLACE (Street) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, return to and complete item 8-d</small>	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits other to myself or to the party who accepts assignment herein.  SIGNED _____ DATE _____		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident OR PRE-EXISTING ILLNESS) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM ONE BY LINE) 1. <b>L010 D</b>		22. MEDICARE RESUBMISSION CODE ORIGINAL REF NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY		B Place of Service	
C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E DIAGNOSIS CODE		F \$ CHARGES	
G DAYS EPID/ OR UNITS		H Family Plan	
I ENG		J COB	
K RESERVED FOR LOCAL USE			
25. FEDERAL TAX ID NUMBER SBN EIN		26. PATIENT'S ACCOUNT NO. <b>1234KD</b>	
27. ACCEPT ASSIGNMENT? (Per gov. statute, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ <b>XXX.XX</b>	
29. AMOUNT PAID \$		30. BALANCE DUE \$ <b>XXX.XX</b>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) <b>I.M. Authorized MM/DD/YY</b>		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing 1 W. Williams Anytown, WI 55555 65432100</b>			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/86)
PLEASE PRINT OR TYPE
FORM HCFA-1500 (12-81)  
FORM OWCP-1500 FORM RFB-1800

## Attachment 8

# UB-92 Billing Instructions for TB-related Services

Those providers who use the UB-92 claim form (home health agencies, hospitals, personal care agencies, rural health clinics) must use the existing UB-92 billing instructions when billing for TB-related services with the following qualifications.

### Home Health Agencies and Personal Care Agencies

Home health agencies and personal care agencies must follow UB-92 billing instructions for Medicaid published in the Wisconsin UB-92 Billing Manual. These providers must avoid duplication of reimbursement between currently covered services (home health, private duty nursing, and personal care services) and the new TB-related services. Inappropriate reimbursement will be recouped in post-pay audits.

### Rural Health Clinics

Rural health clinics must bill for TB-related services using the rural health clinic encounter revenue code, 52X. As of July 1, 1996, rural health clinics must use the HCFA 1500 form and instructions. Until July 1, follow the UB-92 billing instructions for Medicaid published in the Wisconsin UB-92 Billing Manual.

### Outpatient Hospitals

Indicate Revenue Code 519 when billing for the new TB-related services. (Do *not* include the HCPCS codes.)

When billing for all other TB-related services described in this *Update*, outpatient hospitals must bill using the appropriate revenue codes (e.g., revenue code 324 for chest x-ray) or the appropriate revenue code and CPT code combination for laboratory services. Follow the UB-92 billing instructions for Medicaid published in the Wisconsin UB-92 Billing Manual.