WISCONSIN MEDICAID UPDATE

AUGUST 13, 1997

UPDATE 97-22

TO:
All Providers
HMOs and other Managed Care Programs

Provider-Based Billing

This update replaces Update 95-53, issued December 22, 1995.

What is a provider-based billing claim?

Provider-based billing reduces Medicaid costs by ensuring that maximum reimbursement for covered services is received from health care plans that are primary to Wisconsin Medicaid. In other words, Wisconsin Medicaid is the payer of last resort (except for a certain few governmental programs).

A provider-based billing claim is a completed claim form that Wisconsin Medicaid sends to providers for services Wisconsin Medicaid has already paid. A provider-based billing claim is created when the following occurs:

1. Wisconsin Medicaid retroactively identifies that another health care plan exists and may cover those services.

2. To process the claim, the other health care plan may require additional documentation from the provider.

Since benefits under Wisconsin Medicaid are secondary to those provided by health insurance, providers are required to seek reimbursement from the health insurance [HFS 106.03 (7), Wis. Admin. Code]. Providers may not bill the recipient for these services.

When Wisconsin Medicaid produces provider-based billing claims

Wisconsin Medicaid has produced provider-based billing claims for Medicare Part A covered services since September 1994. On January 29, 1996, Wisconsin Medicaid began producing provider-based billing claims for CHAMPUS and commercial health insurance.

The rest of this update gives information on provider-based billing and what providers need to do.

What happens when providers receive a provider-based billing claim?

When Wisconsin Medicaid sends provider-based billing claims to providers, a Provider-Based Billing Summary is also sent. The summary lists each Medicaid claim that a provider-based billing claim form was generated from and its corresponding claim internal control number (ICN).

Within 120 days of the date on the Provider- Based Billing Summary, providers must provide information to document that they have accurately billed the responsible health insurance company and received or have been denied payment.

If Wisconsin Medicaid does not receive a response within 120 days of the date of the Provider-Based Billing Summary, Wisconsin Medicaid will temporarily defer future payments in the amount equal to the original Medicaid payment. *Payment deferral is not a final action; therefore, it is not necessary to request a hearing.* Wisconsin Medicaid will accept documentation of the insurance company's payment, denial, or non-action after 120 days have elapsed.

Provider instructions within 120 days

When you receive the provider-based billing claim(s), please take the following actions for each claim within 120 days:

1. File claim(s) to the health insurance company for the ICNs identified on the Provider-Based Billing Summary. The recipient's designated insurance company appears at the top right corner.

   - Prepared claims are included for your convenience so that you may bill the insurance company. You may use them or produce your own.

   - Attach all additional documentation required by the insurance company, including the Explanation of Medicare Benefits, if applicable.

   - You may find more than one claim per service due to a recipient having multiple insurance coverages. Please coordinate benefits with the insurance companies.

2. If the insurance company pays or partially pays your claim(s), you must forward copies of the insurance company's Explanation of Benefits and the Provider-Based Billing Summary to the EDS Coordination of Benefits Unit.

3. If the insurance company denies your claim, you must submit documentation of the denial along with a copy of the Provider-Based Billing Summary. Submit both to the EDS Coordination of Benefits Unit. Documentation of the denial may be in the form of:

   - Insurance company's Explanation of Benefits.

   - A written statement from the insurance company identifying its reason for denial.

   - A letter from the insurance company indicating a termination date of the policy which precedes the dates of service.

   - Documentation indicating that the insurance company paid the recipient.

   - A copy of the insurance card or other documentation from the insurance company that indicates the policy provides limited coverage such as pharmacy, dental, Medicare supplemental coverage only, etc.

   If your records indicate the insurance information is invalid, you may call EDS at (608) 221-4746, ext. 3142. You will need to fax the corresponding Provider-Based Billing Summary at the time of the phone call. The fax number is (608) 221-4567.

4. Send all responses, including supporting documentation and the Provider-Based Billing Summary, to:

   COORDINATION OF BENEFITS UNIT
   EDS
   P O BOX 6220
   MADISON WI 53716-0220

Provider instructions after 120 days

When payment deferral has already occurred:

1. If a payment or denial is received from the insurance company and the claim date of service is within 12 months of the date of the Provider-Based Billing Summary, submit a Medicaid claim with the appropriate insurance indicator to EDS through normal processing channels. (Do not use the prepared provider-based billing claim(s) that we sent you.)

   Please include the insurance payment amount on the claim when appropriate. For information on the correct use of insurance indicators, refer to Appendix 18 in Part A, the all-provider handbook.

2. If a payment or denial is received from the insurance company and the claim date of service is *more* than 12 months prior to the date of the Provider-Based Billing Summary, you may submit a Medicaid claim with the appropriate insurance indicator to:

   EDS
   6406 BRIDGE ROAD SUITE 50
   MADISON WI 53784-0050

   (Do *not* use the prepared provider-based billing claim(s) that we sent you.) For information on the correct use of insurance indicators, refer to Appendix 18 in Part A, the all-provider handbook.

   Please include documentation of payment or denial and the Provider-Based Billing Summary.

3. If the insurance company does not respond to an initial and follow-up claim, and the claim date of service is *within* 12 months of the date of the Provider-Based Billing Summary, you may submit a claim using insurance indicator "OI-Y" to EDS through normal processing channels.

4. If the insurance company does not respond to an initial and follow-up claim, and the claim date of service is *more* than 12 months prior to the date of the Provider-Based Billing Summary, you may submit a claim using insurance indicator "OI-Y" along with the Provider-Based Billing Summary to:

   EDS
   6406 BRIDGE ROAD SUITE 50
   MADISON WI 53784-0050

Who can answer questions about a specific provider-based billing claim?

You can direct questions about a specific provider-based bill to: EDS Coordination of Benefits Unit at (608) 221-4746, ext. 3142.

Frequently asked questions about provider-based billing

Q. *How does Wisconsin Medicaid receive health insurance information?*

A. Wisconsin Medicaid receives health insurance information from a variety of sources, most often directly from the insurance companies through monthly tape submissions or from county agencies that determine Medicaid eligibility. Wisconsin Medicaid receives additional information from providers via the TPL-17 form.

Q. *Why can't Wisconsin Medicaid bill the insurance company directly for the services?*

A. The services for which provider-based bills are created are those which Wisconsin Medicaid has determined may require additional documentation from the service providers in order to be processed by the insurance company. This additional documentation could be in the form of medical records or other information.

Q. *Can providers send a cash refund to Wisconsin Medicaid?*

A. Yes. Please send the cash refund, along with the Provider-Based Billing Summary to:

COORDINATION OF BENEFITS UNIT
EDS
P O BOX 6220
MADISON WI 53716-0220

Q. *Some health insurance companies are charging copying costs to providers. Is this billable to Wisconsin Medicaid?*

A. No. Administrative costs are not billable to Wisconsin Medicaid.

Q. *Why are provider-based bills for newborns being produced when the mother is covered by health insurance, but the newborn is not covered under her policy?*

A. Providers bill Wisconsin Medicaid under the mother's Medicaid number until one is assigned to the newborn. Thus, in these cases, it is the mother's Medicaid file that is accessed for information used in the provider-based billing process. However, this is a short-term problem since most newborns are assigned their own numbers very soon after birth.

Q. *What should a provider do if the health insurance is a private HMO, the provider did not follow HMO guidelines because coverage was not displayed on the Medicaid card until after the service was provided, and the HMO won't pay the provider-based bill?*

A. Submit the HMO's Explanation of Benefits with the Provider-Based Billing Summary to EDS.

Q. *What if the health insurance is CHAMPUS, and the provider is not able to locate the patient to obtain a signature?*

A. No signature is necessary to bill health insurance since Wisconsin Medicaid has assignment rights.

Q. *How can a provider bill for claims older than 12 months when he or she doesn't have the patient's group or policy number?*

A. The policy number is always displayed on the provider-based bill(s). If you are unable to locate this number on the bill, please contact EDS Correspondence Unit for Policy/Billing Informaton for assistance. If the group number is available, it is also displayed on the provider-based bill(s). If you need the group number and it is not on the provider-based bill(s), contact the recipient or the insurance company for this information.