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# Preface

The Wisconsin Medicaid and BadgerCare Nurse Anesthetist and Anesthesiologist Assistant Services Handbook is issued to certified registered nurse anesthetists and anesthesiologist assistants who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% (as of January 2001) of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

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Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

## Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

## Handbook Organization

The Nurse Anesthetist and Anesthesiologist Assistant Services Handbook consists of the following chapters:

- General Information.
- Anesthesia Services.
- Billing Basics.

In addition to the Nurse Anesthetist and Anesthesiologist Assistant Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

## Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

### Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430 - 456 -- Public Health.

# General Information

The Nurse Anesthetist and Anesthesiologist Assistant Services Handbook includes information for *certified registered nurse anesthetists (CRNAs)* and *anesthesiologist assistants (AAs)* about covered services, reimbursement methodology, and billing.

Wisconsin Medicaid reimburses only those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective.

Anesthesiologists should refer to the Physician Services Handbook, Anesthesia section, which includes information about covered services, reimbursement methodology, and billing.

For further information, go to Wisconsin Medicaid's Web site, *www.dhfs.state.wi.us/medicaid/*, which contains publications that may be downloaded, including Wisconsin Medicaid and BadgerCare handbooks and *Updates*.

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## What are Medicaid-Covered Nurse Anesthetist and Anesthesiologist Assistant Services?

Services provided by CRNAs and AAs include those anesthesia services prescribed by a physician that are within the scope of practice permitted CRNAs and AAs by their professional standards of practice. Refer to Appendix 1 of this handbook for a list of procedure codes covered by Wisconsin Medicaid for CRNAs and AAs.

Wisconsin Medicaid reimburses only those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective. (Refer to the Glossary for Wisconsin Medicaid's definition of medically necessary services.)

Refer to HFS 107.03, Wis. Admin. Code, and to HFS 107.06(5), Wis. Admin. Code, for services *not covered* by Wisconsin Medicaid.

Appendix 8 of this handbook is a partial list of noncovered services. Wisconsin Medicaid does not reimburse for anesthesia services provided with a noncovered service.

## Provider Eligibility and Certification

### Certified Registered Nurse Anesthetist

To become a Wisconsin Medicaid-certified provider, a CRNA must be licensed as a registered nurse pursuant to s. 441.06, Wis. Stats.

A CRNA must also meet one of the following requirements:

- Current certification by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.
- Graduation within the previous 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and awaiting initial CRNA certification.

### Anesthesiologist Assistant

To become a Wisconsin Medicaid-certified provider, an AA must have successfully completed both of the following:

- A four-year bachelor degree.
- An accredited two-year program for anesthesiologist assistants, consisting of specialized academic and clinical training in anesthesia.

## Provider Numbers

Wisconsin Medicaid issues providers, whether individuals, agencies, or institutions, an eight-

of Important Telephone Numbers at the beginning of this handbook.

## Medicaid Managed Care Coverage

Wisconsin Medicaid HMOs are required to provide at least the same benefits for enrollees as those provided under fee-for-service arrangements. For recipients enrolled in a Medicaid managed care program, all conditions of reimbursement and prior authorization (PA) for CRNA and AA services are established by the contract between the managed care program and the provider. Wisconsin Medicaid denies reimbursement for services covered by the recipient's Medicaid managed care program.

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

Additional information regarding Medicaid managed care program noncovered services, emergency services, and hospitalization is located in the *Wisconsin Medicaid Managed Care Guide*.

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## Coordination of Benefits

### Health Insurance Coverage

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under commercial health insurance, Wisconsin Medicaid reimburses that portion of Medicaid's allowable cost remaining after commercial health insurance sources have been exhausted.

In some cases, Wisconsin Medicaid is the primary payer and must be billed *first*. Payers secondary to Medicaid include governmental programs such as:

- Birth to 3.
- The Crime Victim Compensation Fund.
- General Assistance (GA).
- Title V of the Social Security Act, Maternal and Child Health Services.
- The Wisconsin Adult Cystic Fibrosis Program.
- The Wisconsin Chronic Renal Disease Program.
- The Wisconsin Hemophilia Home Care Program.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring health insurance billing, exceptions, the Other Coverage Discrepancy Report, and payers secondary to Medicaid.

### Medicare Coverage

Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be billed to Medicare prior to Wisconsin Medicaid.

Nurse anesthetists and anesthesiologist assistants not certified by Medicare may be retroactively certified by Medicare for the date a service was provided. Contact the appropriate Medicare fiscal intermediary for certification information.

Providers are required to accept assignment on Medicare claims for dual entitlees. The dual entitlee is not liable for Medicare's coinsurance or deductible.

Usually, *Medicare-allowed* claims (called crossover claims) are automatically forwarded by Medicare to Wisconsin Medicaid for processing. If Wisconsin Medicaid has the provider's Medicare provider number, it will reimburse for the coinsurance and deductible within certain limits. These limits are described in the Coordination of Benefits section of the All-Provider Handbook. Medicaid reimburses for the coinsurance and deductible on crossover claims even if the service is not a Medicaid-covered service.

If the service provided to a dual entitlee is covered by Medicare (in at least some situations), but *Medicare denied* the service on a correctly completed claim, submit a new claim for the denied service to Medicaid and

Hospitals are required to obtain PA from Wisconsin Medicaid for all major organ transplants, even if the recipient is enrolled in a Medicaid managed care program.

"No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation to a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s. 49.49, Wis. Stats., and HFS 106.06(17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, or both."

Provider's Name
Provider's Medicaid Number
Provider's Signature and Date

## Documentation Requirement for Abortion, Hysterectomy, and Sterilization Claims

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Wisconsin Medicaid requires *physicians* to attach specific documentation to claims when billing for abortions, hysterectomies, or sterilization procedures. *Before* providing anesthesia services for one of these procedures, CRNAs and AAs are advised to verify with the physician's office that the physician has obtained the necessary documentation. If the required documentation is not attached to the physician's claim, the physician's claim and *all* other claims related to the surgery are denied reimbursement. This includes the CRNA or AA's claim.

## Prior Authorization for Major Organ Transplants

Nurse anesthetists and anesthesiologist assistants are not required to obtain PA. However, hospitals are required to obtain PA from Wisconsin Medicaid for all major organ transplants, even if the recipient is enrolled in a Medicaid managed care program. If the hospital fails to obtain PA, all claims for the transplant, including anesthesia services, are denied reimbursement.

For a list of major organ transplant services requiring PA, refer to the Hospital Handbook or to the Medicine and Surgery section of the Physician Services Handbook, which is available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

# Anesthesia Services

## Anesthesia

Wisconsin Medicaid-covered services provided by a certified registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA) include those anesthesia services prescribed by a physician within the scope of practice permitted CRNAs and AAs by their professional standards of practice.

For billing purposes, CRNA and AA services are considered either *medically directed* or *medically supervised.*

### Supervision Requirements

Nurse anesthetist and anesthesiologist assistant services must be provided in the presence of a supervising anesthesiologist or a performing physician, according to HFS 107.065, Wis. Admin. Code.

For billing purposes, CRNA and AA services are considered either *medically directed* or *medically supervised.* Anesthesiologist assistants must work under the medical direction of an anesthesiologist who is physically present during the provision of services. Nurse anesthetists may be either medically directed by an anesthesiologist *or* medically supervised by the attending physician.

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#### *Medically Directed Anesthesia Services*

Medically directed anesthesia services are those services performed by a CRNA or an AA and directed by an anesthesiologist. When a CRNA or AA is medically directed, the anesthesiologist must do *all* of the following:

1. Perform pre-anesthesia examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable.
4. Monitor at frequent intervals the course of anesthesia administered.
5. Remain physically present and available for immediate diagnosis and treatment of emergencies.
6. Indicate post-anesthesia care.

#### *Medically Supervised Anesthesia Services*

Medically supervised anesthesia services are those services performed by a CRNA and supervised by the attending physician. When a CRNA is medically supervised, the attending physician:

1. Reviews and verifies the pre-anesthesia evaluation performed by the CRNA.
2. Reviews the anesthesia plan, including medication.
3. Reviews and comments during pre-anesthesia care.
4. Reviews and comments during post-anesthesia care.

#### *Medically Directed vs. Medically Supervised Anesthesia Services*

For medically directed anesthesia services, an anesthesiologist is present during critical points in the procedure and is immediately available for diagnosis and treatment of emergencies. However, when a CRNA is medically supervised by the attending physician, an anesthesiologist does not have to be present during critical points in the procedure or immediately available for diagnosis and treatment of an emergency.

Anesthesiologist assistants must perform services under the medical direction of an anesthesiologist. Therefore, they *cannot* perform medically supervised anesthesia services.

Wisconsin Medicaid does *not* reimburse separately for anesthesia time when an epidural anesthesia procedure is performed, except as part of labor and delivery.

Wisconsin Medicaid reimburses anesthesia only for the CPT procedure code applicable to the *major* surgical, therapeutic, or diagnostic procedure performed when multiple procedures are performed in a single surgical session. Assign to that procedure code the number of 15-minute time units involved in the *total* surgical session.

Use the following guidelines to determine the number of units to bill:

*Rounding Guidelines*

| Time (in minutes) | Unit(s) Billed |
|---|---|
| 1-15 | 1.0 |
| 16-30 | 2.0 |
| 31-45 | 3.0 |
| 46-60 | 4.0 |
| etc. | |

## Additional Nurse Anesthetist or Anesthesiologist Assistant

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An additional CRNA or AA may be required in certain surgical situations. Reimbursement for the additional provider is established by the Medicaid physician consultant.

## Standby Nurse Anesthetist or Anesthesiologist Assistant

Wisconsin Medicaid reimburses for a standby CRNA or AA when the attending physician requests a CRNA or AA be immediately available on the premises. The standby CRNA or AA monitors the recipient's vital signs and observes the recipient, even though the surgery is actually performed under local anesthesia. Wisconsin Medicaid reimburses the standby CRNA or AA as if general anesthesia had been administered. A standby CRNA or AA is covered only when medically necessary and documented in the recipient's medical record.

Standby anesthesia is not covered when anesthesia, including an epidural, has already been administered.

To bill for a standby CRNA or AA, include the following on the HCFA 1500 claim form:

- The procedure code best describing the procedure performed.
- TOS "7."
- The number of 15-minute time units the CRNA or AA was face-to-face with the recipient or immediately available on the premises during a procedure.

## Emergency Intubation

Nurse anesthetists and anesthesiologist assistants may be reimbursed for emergency intubations performed in a hospital unit other than the operating room. The procedure should be billed as a one-time event using procedure code 31500 (intubation, endotracheal, emergency procedure) and surgical TOS "2." Indicate a quantity of "1.0" when billing for intubation. Do *not* indicate the number of 15-minute time units as the quantity.

## Epidural Anesthesia

Wisconsin Medicaid does *not* reimburse separately for anesthesia time when an epidural anesthesia procedure is performed, except as part of labor and delivery. Refer to the example on the following page to determine time units for an epidural anesthesia performed as part of labor and delivery.

### Obstetrical

A CRNA or AA's time spent in attendance with an obstetrical patient receiving epidural anesthesia as part of labor and delivery may be reimbursed. Time spent in attendance includes:

- Initiation of the epidural.
- Initial care.
- Intermittent face-to-face monitoring.
- Discontinuation of the epidural.

Providers should bill the appropriate labor and delivery procedure code, TOS "7," and appropriate 15-minute time units. Document in the recipient's medical record or anesthesia report the time actually spent in constant attendance with the recipient.

# Billing Basics

## Claim Submission

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

### Electronic Billing

Providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided.

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic billing:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

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If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's customer service at (800) 822-8050.

### Paper Claim Submission

Providers submitting paper claims must use the HCFA 1500 claim form (dated 12/90). Refer to Appendix 2 of this handbook for HCFA 1500 claim form completion instructions and Appendices 3 and 4 of this handbook for sample completed claim forms.

Wisconsin Medicaid denies claims for services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. You may obtain the form from any vendor that sells federal forms.

### Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments Unit
6406 Bridge Road
Madison, WI 53784-0002

## Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook on-line at *www.dhfs.state.wi.us/medicaid/*. If you wish to make adjustments, refer to Appendices 5, 6, and 7 of this handbook.

## Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook. Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

## Follow Up to Claim Submission

The All-Provider Handbook includes the appropriate procedures for claim follow up, including:

- The Remittance and Status (R/S) Report.
- Adjustments to paid claims (refer to Appendices 5, 6, and 7 for the Adjustment Request Form completion instructions, a completed sample form, and a blank form for photocopying).
- Return of overpayments.
- Duplicate payments.

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# Appendix

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# Appendix 1

## Wisconsin Medicaid-Allowable Procedure Codes, Modifiers, TOS Codes, POS Codes, and Rounding Guidelines for CRNA and AA Services

Some procedure codes displayed within the ranges below may not be covered by Wisconsin Medicaid. Call Provider Services regarding coverage of specific procedure and type of service code combinations. The chart below is periodically revised.

| Wisconsin Medicaid-Allowable CRNA and AA Services | | |
|---|---|---|
| Service | Procedure Codes | TOS |
| Surgery | 10040-69999 | 7 (anesthesia) |
| Intubation | 31500 | 2 (surgery) |
| Vascular procedures | 36000-36248, 36488-36491, 36600-36660 | 2<br>allowable when anesthesia not provided |
| Invasive monitoring | 36488, 36489, 36620, 93503 | 7 |
| Radiology | 70010-79999 (Anesthesia for radiology procedures is allowed only if the complexity of the procedure and the physical condition of the patient make it medically necessary.) | 7 |
| Medicine - psychiatry | 90870, 90871 | 7 |
| Medicine - ophthalmology | 92018, 92019 | 7 |
| Medicine - special otorhinolaryngologic services | 92502 | 7 |
| Medicine - cardiovascular | 92950-92998, 93278-93660, 93724, 93731-93738, 93799, 93875-93990 | 7 |
| Medicine - pulmonary | 94799 | 7 |

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| Modifiers for CRNAs and AAs | | |
|---|---|---|
| Modifier | Provider | Description |
| WP | CRNA or AA | CRNA or AA is one of two, three, or four CRNAs or AAs being medically directed |
| WD | CRNA or AA | CRNA or AA is the *only* CRNA or AA being medically directed |
| WJ | CRNA only | CRNA is medically supervised |

| Rounding Guidelines | |
|---|---|
| Time (in minutes) | Unit(s) Billed |
| 1-15 | 1.0 |
| 16-30 | 2.0 |
| 31-45 | 3.0 |
| 46-60 | 4.0 |
| 61-75 | 5.0 |
| 76-90 | 6.0 |
| 91-105 | 7.0 |
| etc. | |

| POS Codes | |
|---|---|
| POS | Description |
| 0 | Other |
| 1 | Inpatient Hospital |
| 2 | Outpatient Hospital |
| 3 | Office |
| 7 | Nursing Home |
| 8 | Skilled Nursing Facility |
| B | Ambulatory Surgical Center |

POS: Place of Service
TOS: Type of Service
CRNA: Certified Registered Nurse Anesthetist
AA: Anesthesiologist Assistant

# Appendix 2

## HCFA 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

***Note:*** Medicaid providers should ***always*** verify recipient eligibility before rendering services.

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

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

### Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid ID number. Do not enter any other numbers or letters.

### Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

### 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) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female by placing an "X" in the appropriate box.

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

### Element 5 — Patient's Address

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

***Mother/Baby Claims***

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service and the mother of the infant is a Medicaid recipient.

To bill for an infant using the mother's Medicaid identification number, enter the following:

*Element 1a:* Enter the mother's 10-digit Medicaid ID number.

*Element 2:* Enter the mother's last name followed by "newborn."

*Element 3:* Enter the *infant's* date of birth.

*Element 4:* Enter the mother's name followed by "mom" in parentheses.

*Element 21:* Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

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### 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

Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental ("DEN") insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, *and* the service requires third-party billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes *must* be indicated in the *first* box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

| Code | Description |
|---|---|
| **OI-P** | PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured. |

*For Medicare Part A* (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 provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

*For Medicare Part B* (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 provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

**M-5** **Provider is not Medicare certified.** This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates. Use M-5 in these two instances only:

*For Medicare Part A* (all three criteria must be met):
- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not 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* (all three criteria must be met):
- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

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**M-6** **Recipient not Medicare eligible.** This code can be used when Medicare denies payment for services related to *chronic renal failure* (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

*For Medicare Part A* (all three criteria must be met):
- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

*For Medicare Part B* (all three criteria must be met):
- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

**M-7** **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

*For Medicare Part A* (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, etc.

*For Medicare Part B* (all three criteria must be met):
- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.

Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. One source to order the complete ICD-9-CM code book is:

St. Anthony Publishing, Inc.
PO Box 96561
Washington, DC 20090
(800) 632-0123

### Element 22 — Medicaid Resubmission (not required)

### Element 23 — Prior Authorization Number (not required)

### Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in Element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

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### Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. Refer to Appendix 1 for a list of POS codes for certified registered nurse anesthetist (CRNA) and anesthesiologist assistant (AA) services.

### Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 1 for a list of TOS codes for CRNA and AA services.

### Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code. Claims received without an appropriate procedure code are denied by Wisconsin Medicaid.

Each year, Wisconsin Medicaid adopts the most current CPT procedure codes. (The exact date is announced in a Remittance and Status [R/S] Report message.)

## Appendix 2
## (continued)

### Element 29 — Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.) Do *not* enter Medicare-paid amounts in this field.

### 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 or MM/DD/YYYY format.

*Note:* The signature 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 Were Rendered (not required)

### 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.

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for current policy

# Appendix 3

## Completed Sample HCFA 1500 Claim Form – Medically Directed Anesthesia Services (Performed by CRNAs or AAs)

APPROVED OMB-0938-0008

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [P] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M - 7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M / F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M / F

b. AUTO ACCIDENT? YES / NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES / NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. 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 government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 575 1
2. ___
3. ___
4. ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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Refer to the Online Handbook
for current policy

| 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 OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 MM DD YY | | 1 | 7 | 47600 | WP | 1 | XX XX | 8.0 | | | | 12345678 |
| 2 | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED — DATE

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 #

I.M. Billing
1 W. Williams
Anytown, WI 55555 — 87654321

PIN# — GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — **PLEASE PRINT OR TYPE** — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

# Appendix 4

## Completed Sample HCFA 1500 Claim Form – Medically Supervised Anesthesia Services (Performed by CRNAs Only)

PICA

**HEALTH INSURANCE CLAIM FORM**

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) **P** CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** SEX M F **X**

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): **609 Willow**

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: **Anytown** STATE: **WI**

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX) XXX-XXXX**

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): **OI-P**

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: **M - 7**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. 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 government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **575 . 1**
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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for current policy

| 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 OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 MM DD YY | | 1 | 7 | 47600 | WJ | 1 | XX XX | 8.0 | | | | 12345678 |
| 2 | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: **1234JED**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ **XX XX**

29. AMOUNT PAID: $ **XX XX**

30. BALANCE DUE: $ **XX XX**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

**I.M. Authorized** **MM/DD/YY**

SIGNED DATE

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 #

**I.M. Billing**
**1 W. Williams**
**Anytown, WI 55555**

PIN# GRP# **87654321**

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Appendix

# Appendix 5

## Adjustment Request Form Completion Instructions

The Adjustment Request Form is used to request an adjustment of a paid or partially paid claim. Providers may request an adjustment when claim information needs to be changed. After the changes are made to the original claim, the adjusted claim is processed according to Medicaid guidelines.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted through normal channels after the additional information has been supplied or the necessary correction has been made to the claim.

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

The Adjustment Request Form is reviewed by Wisconsin Medicaid based on the information provided to the Medicaid fiscal agent. Be as specific as possible when describing how the original claim is to be changed. Complete the adjustment request as follows:

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### Step 1: Enter the following information from your Remittance and Status (R/S) Report:

1. Provider name.
2. Wisconsin Medicaid provider number to which the claim was paid (8 digits).
3. Date of the R/S Report showing the paid claim you are adjusting.
4. Claim number of the paid/allowed claim (15 digits).
5. Complete name of the Wisconsin Medicaid recipient for whom payment was received (Last, First, MI).
6. Recipient's Wisconsin Medicaid ID number (10 digits).

### Step 2: Add a detail(s).

If submitting an adjustment to add a detail(s) to a paid/allowed claim, enter the complete information you are requesting to be added to the claim in elements 7 through 15.

### Correct a detail(s).

If submitting an adjustment to correct a detail(s) on a paid/allowed claim, enter the information from the R/S Report in elements 7 through 15. Enter the correct information in the comment area.

### Step 3: Indicate reason for adjustment.

16. Check one of the following boxes indicating your reason for submitting the adjustment:
    - *Recoup entire MA payment.* This would include claims billed in error or completely paid by another insurance carrier.
    - *Other insurance payment.* Enter the amount paid by the other insurance carrier.
    - *Copay deducted in error.* Indicate if the recipient was a nursing home resident on the date of service, or the correct number of covered service days, or if an emergency service was provided.
    - *Medicare reconsideration.* Attach both the original and the new Explanation of Medicare Benefits (EOMB). (If the claim was paid as a straight Wisconsin Medicaid claim, submit an adjustment to recoup that claim. Then submit a new day claim with the EOMB's attached.)
    - *Correct detail.* Use the R/S Report to complete elements 7 through 15 with information about the claim to be adjusted. Enter the correct information in the comment area.
    - *Other/comments.* Add any clarifying information not included above. If there are extenuating circumstances, complicated or new procedures, indicate "For Consultant Review" and attach appropriate documentation such as a history and physical, operative report, or anesthesia report.

### Step 4: Enter the following:

*17. Authorized signature.

*18. Date of signature. Use either the MM/DD/YY format or the MM/DD/YYYY format.

19. Indicate if a corrected claim form is attached. This is optional but may allow your adjustment to be processed more quickly and accurately.

* If the date or signature is missing on the Adjustment Request Form, the claim will be denied.

# Appendix 6

## Completed Sample Wisconsin Medicaid Adjustment Request Form

1. PROVIDER NAME: I. M. Billing
2. PROVIDER NUMBER: 8 7 6 5 4 3 2 1

DO NOT WRITE IN THIS SPACE

3. R&S DATE: MMDDYY
5. RECIPIENT NAME: Recipient, Im A.

4. CLAIM NUMBER: 2 0 9 8 9 9 1 2 3 5 5 5 5 5 0
6. RECIPIENT NUMBER: 1 2 3 4 5 6 7 8 9 0

☐ ADD NEW DETAIL(S) TO PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information to be added)

☒ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information as it appears on R&S report)

| 7. DATE(S) OF SERVICE FROM | TO | 8. POS | 9. TOS | 10. PROCEDURE/ NDC/REVENUE CODE | MOD | MOD | 11. BILLED AMT | 12. UNIT QTY | 13. EPSDT FAM PLAN | 14. EMG | 15. PERFORMING PROVIDER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MMDDYY | | 1 | 7 | 58600 | WP | | XX.XX | 8.0 | | | 12345678 |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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16. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE MA PAYMENT

☐ OTHER INSURANCE PAYMENT $ ______________ (OI-P)

☐ COPAY DEDUCTED IN ERROR: ☐ RECIPIENT IN NURSING HOME ☐ COVERED DAYS ______ ☐ EMERGENCY

☐ MEDICARE RECONSIDERATION (EOMB's ATTACHED)

☒ CORRECT DETAIL (In 7-15, enter information as it appears on R&S report. Enter correct information in comment area)

☐ OTHER/COMMENTS:

Please change the quantity from 8.0 units to 9.0 and reprocess for payment.
Thank you.

17. SIGNATURE: I. M. Provider
18. DATE: MMDDYY

19. ☐ CLAIM FORM ATTACHED (OPTIONAL)

MAIL TO: EDS
6406 BRIDGE ROAD
MADISON, WI 53784-0002

Appendix

## Appendix 7

## Wisconsin Medicaid Adjustment Request Form (for photocopying)

### WMAP ADJUSTMENT REQUEST FORM

1. PROVIDER NAME ______________ 2. PROVIDER NUMBER [ | | | | | | | | ] DO NOT WRITE IN THIS SPACE

3. R&S DATE ______________ 5. RECIPIENT NAME ______________

4. CLAIM NUMBER 6. RECIPIENT NUMBER

☐ ADD NEW DETAIL(S) TO PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information to be added)

☐ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information as it appears on R&S report)

| 7. DATE(S) OF SERVICE FROM | TO | 8. POS | 9. TOS | 10. PROCEDURE/ NDC/REVENUE CODE | MOD | MOD | 11. BILLED AMT | 12. UNIT QTY | 13. EPSDT FAM PLAN | 14. EMG | 15. PERFORMING PROVIDER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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for current policy

16. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE MA PAYMENT

☐ OTHER INSURANCE PAYMENT $ ______________ (OI-P)

☐ COPAY DEDUCTED IN ERROR: ☐ RECIPIENT IN NURSING HOME ☐ COVERED DAYS ______ ☐ EMERGENCY

☐ MEDICARE RECONSIDERATION (EOMB's ATTACHED)

☐ CORRECT DETAIL (In 7-15, enter information as it appears on R&S report. Enter correct information in comment area)

☐ OTHER/COMMENTS:

17. SIGNATURE 18. DATE

INSTRUCTIONS: (SEE REVERSE SIDE FOR FURTHER INSTRUCTIONS)

MAIL TO: EDS
6406 BRIDGE ROAD
MADISON, WI 53784-0002

19. ☐ CLAIM FORM ATTACHED (OPTIONAL)

Appendix

# Appendix 8

## Services Not Covered by Wisconsin Medicaid

The following specific services are not covered by Wisconsin Medicaid. This list is not all inclusive.

### HFS 107.03 "Services not covered."

HFS 107.03, Wis. Admin. Code, defines "services not covered" under Wisconsin Medicaid to include the following:

(1) Charges for telephone calls;
(2) Charges for missed appointments;
(3) Sales tax on items for resale;
(4) Services provided by a particular provider that are considered experimental in nature;
(5) Procedures considered by the department to be obsolete, inaccurate, unreliable, ineffectual, unnecessary, imprudent or superfluous;
(6) Personal comfort items, such as radios, television sets and telephones, which do not contribute meaningfully to the treatment of an illness;
(7) Alcoholic beverages, even if prescribed for remedial or therapeutic reasons;
(8) Autopsies;
(9) Any service requiring prior authorization for which prior authorization is denied, or for which prior authorization was not obtained prior to the provision of the service except in emergency circumstances;
(10) Services subject to review and approval pursuant to s. 150.21, Stats., but which have not yet received approval;
(11) Psychiatric examinations and evaluations ordered by a court following a person's conviction of a crime, pursuant to s. 972.15, Stats.;
(12) Consultations between or among providers, except as specified in s. HFS 107.06 (4) (e);
(13) Medical services for adult inmates of the correctional institutions listed in s. 53.01, Stats.;
(14) Medical services for a child placed in a detention facility;
(15) Expenditures for any service to an individual who is an inmate of a public institution or for any service to a person 21 to 64 years of age who is a resident of an institution for mental disease (IMD), unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, except that expenditures for a service to an individual on convalescent leave from an IMD may be reimbursed by Wisconsin Medicaid.
(16) Services provided to recipients when outside the United States, except Canada or Mexico;
(17) Separate charges for the time involved in completing necessary forms, claims or reports;
(18) Services provided by a hospital or professional services provided to a hospital inpatient are not covered services unless billed separately as hospital services under s. HFS 107.08 or 107.13 (1) or as professional services under the appropriate provider type. No recipient may be billed for these services as noncovered;
(19) Services, drugs and items that are provided for the purpose of enhancing the prospects of fertility in males or females, including but not limited to the following:
   (a) Artificial insemination, including but not limited to intra-cervical and intra-uterine insemination;
   (b) Infertility counseling;
   (c) Infertility testing, including but not limited to tubal patency, semen analysis or sperm evaluation;
   (d) Reversal of female sterilization, including but not limited to tubouterine implantation, tubotubal anastomoses or fimbrioplasty;
   (e) Fertility-enhancing drugs used for the treatment of infertility;
   (f) Reversal of vasectomies;
   (g) Office visits, consultations and other encounters to enhance the prospects of fertility; and
   (h) Other fertility-enhancing services and items;
(20) Surrogate parenting and related services, including but not limited to artificial insemination and subsequent obstetrical care;
(21) Ear lobe repair;
(22) Tattoo removal;
(23) Drugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics;
(24) Transsexual surgery;
(25) Impotence devices and services, including but not limited to penile prostheses and external devices and to insertion surgery and other related services; and
(26) Testicular prosthesis.

### HFS 107.06(5) "Non-covered Services."

According to HFS 107.06 (5), Wis. Admin. Code, Wisconsin Medicaid defines the following "non-covered services":

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# Glossary

### AA
An Anesthesiologist assistant.

### Adjustment
A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

### Allowed claim
A Medicaid or Medicare claim that has at least one service that is reimbursable.

### BadgerCare
BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

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### CPT
*Current Procedural Terminology*. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Health Care Financing Administration (HCFA) and Wisconsin Medicaid.

### Crossover claim
A Medicare-allowed claim for a dual entitlee submitted to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

### CRNA
A Certified registered nurse anesthetist.

### DHCF
Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and HCFA policy.

### DHFS
Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

### DHHS
Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

### DOS
Date of service. The calendar date on which a specific medical service is performed.

### Dual entitlee
A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

### ECS
Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

### Medically necessary

According to HFS 101.03 (96m), Wis. Admin.Code, a service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

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### Medically supervised

Those procedures performed by a certified registered nurse anesthetist (CRNA) and supervised by the attending physician.

### Payee

Party to whom checks are made payable. The payee's address is used as the mailing address for checks and Remittance and Status (R/S) Reports.

### POS

Place of service. A single-digit code which identifies the place where the service was performed.

### QMB Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. These recipients are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

### Qualifying circumstances

Conditions that complicate the rendering of anesthesia services, including the extraordinary condition of the patient, special operative conditions, and unusual risk factors.

### R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

### RVU

Relative value unit. A number assigned by Wisconsin Medicaid to indicate the relative clinical intensity and difficulty of the surgical, diagnostic, or therapeutic procedure code for which anesthesia services were performed. Relative value units are not necessarily equivalent to either federal or American Society of Anesthesiologists RVUs. Relative value units are indicated on the Physician Maximum Allowable Fee Schedule.

### Supervision

At least intermittent face-to-face contact between supervisor and assistant and a regular review of the assistant's work by the supervisor, according to HFS 101.03 (173), Wis. Admin. Code.

### TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

# Index

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