All Provider

Coordination of Benefits

ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

Certification and Ongoing Responsibilities
• Certification and recertification. • Change of address or status. • Documentation requirements. • Noncertified providers. • Ongoing responsibilities. • Provider rights. • Provider sanctions. • Recipient discrimination prohibited. • Release of billing information.

Claims Information
• Follow-up procedures. • Good Faith claims. • Preparing and submitting claims. • Reimbursement information. • Remittance information. • Submission deadline. • Timely filing appeals requests.

Coordination of Benefits
• Commercial health insurance. • Crossover claims. • Medicare. • Other Coverage Discrepancy Report, HCF 1159. • Primary and secondary payers. • Provider-based billing.

Covered and Noncovered Services
• Collecting payment from recipients. • Covered services. • Emergency services. • HealthCheck "Other Services." • Medical necessity. • Noncovered services.

Informational Resources
• Electronic transactions. • Eligibility Verification System. • Maximum allowable fee schedules. • Forms. • Medicaid Web site. • Professional relations representatives. • Provider Services. • Publications.

Managed Care
• Covered and noncovered HMO and SSI MCO services. • Enrollee HMO and SSI MCO eligibility. • Enrollment process. • Extraordinary claims. • HMO and SSI MCO claims submission. • Network and non-network provider information. • Provider appeals.

Prior Authorization
• Amending prior authorization (PA) requests. • Appealing PA decisions. • Grant and expiration dates. • Prior authorization for emergency services. • Recipient loss of eligibility during treatment. • Renewal requests. • Review process. • Submitting PA requests.

Recipient Eligibility
• Copayment requirements. • Eligibility categories. • Eligibility responsibilities. • Eligibility verification. • Identification cards. • Limited benefit categories. • Misuse and abuse of benefits. • Retroactive eligibility.

Table of Contents

Preface

This All-Provider Handbook is issued to all Medicaid-certified providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of this handbook for information about state-contracted managed care organizations.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/*.
- *dhfs.wisconsin.gov/badgercare/*.

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

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 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

General Information

Medicaid as Payer of Last Resort

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to a state-contracted managed care organization (MCO).

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

Refer to Appendix 1 of this section and to service-specific publications for more information about services that require other health insurance billing.

Other Health Insurance Sources

Wisconsin Medicaid reimburses only that portion of the Medicaid-allowed cost remaining after a recipient's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial health insurance.
- Commercial managed care plans.
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- Civilian Health and Medical Plan of the Veterans Administration.
- Other governmental benefits.

Non-Medicaid Payments

Wisconsin Medicaid will not reimburse providers if they receive payment from the following sources:

- Civil liabilities (e.g., injuries from an automobile accident).
- Workers' compensation.

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare and Medicare is primary to Wisconsin Medicaid. Therefore, Wisconsin Medicaid is secondary to Medicare and Medicare is secondary to commercial health insurance.

Instances When Medicaid Is Not Payer of Last Resort

Wisconsin Medicaid is *not* the payer of last resort for recipients who receive coverage from certain governmental programs, such as:

- Birth to 3.
- Crime Victim Compensation Fund.
- General Assistance.
- Home and Community-Based Services waiver programs.
- Indian Health Service.
- Individuals with Disabilities Education Act.
- Maternal and Child Health Services.
- Wisconsin Chronic Disease Program.
  - ✓ Wisconsin Adult Cystic Fibrosis Program.
  - ✓ Wisconsin Chronic Renal Disease Program.
  - ✓ Wisconsin Hemophilia Home Care Program.

Providers should ask recipients if they have coverage from these other governmental programs.

If the recipient becomes retroactively eligible for Wisconsin Medicaid, providers who have already been reimbursed by one of these government programs may be required to submit the claims to Wisconsin Medicaid and refund the payment from the government program.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill other health insurance sources to substantiate other insurance indicators or Medicare disclaimer codes used on any claim, according to HFS 106.02(9)(a), Wis. Admin. Code.

Eligibility Verification

Eligibility information is available from the Medicaid Eligibility Verification System (EVS). Providers may use the EVS to verify recipient eligibility and other pertinent information and determine if the recipient has coverage under any of the following:

- Commercial health insurance.
- Medicare.
- State-contracted MCOs.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Refer to the Recipient Eligibility section of this handbook for information about using eligibility verification methods.

Recipient Cooperation

Recipients are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a recipient has other health insurance in addition to Wisconsin Medicaid, it is the recipient's obligation to give full and accurate information to providers regarding the insurance.

Other Coverage Information

Wisconsin Medicaid uses many sources of information to keep accurate and current records of a recipient's other coverage, including the following:

- Insurance Disclosure program.
- Providers who submit an Other Coverage Discrepancy Report form, HCF 1159.
- Recipient certifying agencies.
- Recipients.

The information about a recipient's other coverage in Medicaid recipient files may be incomplete or incorrect if Wisconsin Medicaid received inaccurate information from the other health insurance source or the recipient's certifying agency.

Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Insurance Disclosure Program

Wisconsin Medicaid receives policyholder files from most major commercial health insurance companies on a monthly basis. The insurance company is solely responsible for the accuracy of this data.

Wisconsin Medicaid compares this information with recipient eligibility files. If a recipient has other health insurance, Wisconsin Medicaid updates the recipient's eligibility file with the most current information. If the insurance company provides information that is not current, Wisconsin Medicaid's files may be inaccurate.

Reporting Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Providers are encouraged to report discrepancies to Wisconsin Medicaid by submitting the Other Coverage Discrepancy Report form. Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by the EVS.
- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the recipient (e.g., the recipient does not live in the plan's service area).

Providers should not use the Other Coverage Discrepancy Report form to update any information regarding a recipient's coverage in a state-contracted MCO.

The Other Coverage Discrepancy Report form is located in Appendix 2 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

When reporting discrepancies to Wisconsin Medicaid, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

According to federal regulations, providers cannot hold a Medicaid recipient responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible.

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report form, Wisconsin Medicaid confirms the information and updates Medicaid recipient files.

It may take up to two weeks to process and update the recipient's eligibility information. During that time, Wisconsin Medicaid verifies the insurance information submitted and adds, changes, or removes the recipient's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- The provider verifies through the EVS that the recipient's other coverage information has been updated.
- The provider receives a written explanation from Wisconsin Medicaid.

Cost Sharing

According to federal regulations, providers cannot hold a Medicaid recipient responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a Medicaid recipient, or authorized person acting on behalf of the recipient, for copayments required by other health insurance sources. Instead, the provider should collect *only* the Medicaid copayment amount from the recipient.

Commercial Health Insurance

Providers are required to exhaust commercial health insurance sources before submitting claims to Wisconsin Medicaid.

Providers are required to exhaust commercial health insurance sources before submitting claims to Wisconsin Medicaid. This is accomplished by following the process indicated in Appendix 3 of this section.

Wisconsin Medicaid does not require providers to bill commercial health insurance sources before submitting claims to Wisconsin Medicaid for the following:

- Case management services.
- Crisis intervention services.
- Family planning services.
- Prenatal care coordination services.
- Preventive pediatric services.
- Specialized medical vehicle services.

Definition

Wisconsin Medicaid defines commercial health insurance as any type of health benefit not obtained from Medicare or Wisconsin Medicaid. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan.

Commercial Fee-for-Service

Fee-for-service commercial health insurance is the traditional health care payment system under which providers receive a payment for each unit of service provided rather than a capitation payment for each recipient. Such insurance usually does not restrict health care to a particular network of providers.

Commercial Managed Care

A commercial managed care plan provides coverage through a specified group of providers in a particular service area. The providers may be under contract with the commercial health insurance and receive payment based on the number of patients seen (i.e., capitation payment).

Commercial managed care plans require recipients to use a designated network of providers. Non-network providers (i.e., providers who do not have a contract with the recipient's commercial managed care plan) will be reimbursed by the commercial managed care plan *only* if they obtain a referral or provide an emergency service.

Except for emergency services and Medicaid-covered services that are not covered under the commercial managed care plan, recipients enrolled in both a commercial managed care plan and Wisconsin Medicaid (i.e., state-contracted managed care organization, Medicaid fee-for-service) are required to receive services from providers affiliated with the commercial managed care plan. In this situation, Medicaid providers are required to refer the recipient to commercial managed care providers. This is necessary because commercial health insurance is always primary to Wisconsin Medicaid.

Wisconsin Medicaid will *not* reimburse the provider if the commercial managed care plan denied or would deny payment because a service otherwise covered under the commercial managed care plan was performed by a provider outside the plan. In addition, if a recipient receives a Medicaid-covered service outside his or her commercial managed care plan, the provider cannot collect payment from the recipient.

Non-Reimbursable Commercial Managed Care Services

Wisconsin Medicaid does not reimburse providers for the following:

- Services covered by a commercial managed care plan, except for coinsurance, copayment, or deductible.
- Services for which providers contract with a commercial managed care plan to receive a capitation payment for services.

Recipients Unable to Obtain Services Under Managed Care Plan

Sometimes a recipient's eligibility file shows commercial managed care coverage, but the recipient is unable to receive services from the managed care plan. Examples of such situations include the following:

- Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- Recipients enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.
- Recipients enrolled in a commercial managed care plan who enter a nursing facility that limits the recipient's access to managed care providers.

In these situations, Wisconsin Medicaid will pay for services covered by both Wisconsin Medicaid and the commercial managed care plan even though the services are obtained from providers outside the plan.

When submitting claims for these recipients, providers should do one of the following:

- Indicate "OI-Y" on paper claims.
- Refer to the Wisconsin Provider Electronic Solutions Manual or the appropriate 837 Health Care Claim companion document to determine the appropriate other insurance indicator for electronic claims.

Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by Wisconsin Medicaid, the provider may submit a claim for those services directly to Wisconsin Medicaid. To allow payment by Wisconsin Medicaid in this situation, providers are encouraged to follow Medicaid requirements (e.g., request prior authorization [PA] before providing the service for Medicaid-covered services that require PA). If Medicaid requirements are followed, Wisconsin Medicaid may reimburse for the service up to the Medicaid-allowed amount (less any payments made by other health insurance sources).

If commercial health insurance denies or recoups payment for services that are covered by Wisconsin Medicaid, the provider may submit a claim for those services directly to Wisconsin Medicaid.

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed. Providers are required to use these indicators as applicable on claims submitted to Wisconsin Medicaid for recipients with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement from Wisconsin Medicaid constitutes fraud.

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be reimbursed correctly by Wisconsin Medicaid when the following occur:

- Commercial health insurance exists, does not apply, or when, for some valid reason, the provider is unable to obtain such reimbursement by reasonable means.
- Commercial health insurance does not cover the service provided.
- Full or partial payment was made by commercial health insurance.

Refer to claim instructions for other insurance indicators and their descriptions.

Providers should not use other insurance indicators when the following occur:

- The Medicaid Eligibility Verification System indicates no commercial health insurance for the date of service.
- The service does not require other health insurance billing.

Discounted Rates

Providers of services that are discounted by commercial health insurance should include the following on claims submitted to Wisconsin Medicaid:

- Their usual and customary charge.
- The appropriate other insurance indicator.
- The amount, if any, actually received from commercial health insurance as the amount paid by commercial health insurance.

Pharmacy providers should refer to service-specific publications for information about SeniorCare services that are discounted by commercial health insurance.

If the recipient is assigned insurance benefits, it is appropriate to submit a claim to Wisconsin Medicaid without billing the commercial health insurance.

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (e.g., provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Commercial health insurance companies may permit reimbursement to the provider or recipient. Providers should verify whether commercial health insurance benefits may be assigned to the provider. As indicated by the commercial health insurance, providers may be required to obtain approval from the recipient for this assignment of benefits.

If the provider is assigned benefits, providers should bill the commercial health insurance.

If the recipient is assigned insurance benefits, it is appropriate to submit a claim to Wisconsin Medicaid without billing the commercial health insurance. In this instance providers should indicate the appropriate other insurance indicator. Wisconsin Medicaid will bill the commercial health insurance.

Medicare

Providers are required to exhaust Medicare coverage before submitting claims to Wisconsin Medicaid. This is accomplished by following the process indicated in Appendix 4 of this section.

Definition

Medicare is a health insurance program for people 65 years of age or older, for certain people with disabilities under age 65, and for people with end-stage renal disease. Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into three parts:

- Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health services.
- Part B (i.e., Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as physical therapy services, occupational therapy services, and some home health services).
- Part C (i.e., Medicare Advantage).

Dual Eligibles

Dual eligibles are recipients who are eligible for coverage from Medicare (either Medicare Part A, Part B, or both) *and* Wisconsin Medicaid.

Dual eligibles may receive Medicaid coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.
- Medicaid-covered services, even those that are not allowed by Medicare.

Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary-Only recipients do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare.

Qualified Medicare Beneficiary-Only (QMB-Only) recipients are a limited benefit category of Medicaid recipients. They are eligible for coverage from Medicare (either Part A, Part B, or both) *and* limited coverage from Wisconsin Medicaid. Qualified Medicare Beneficiary-Only recipients receive Medicaid coverage for the following:

- Medicare monthly premiums for Part A, Part B, or both.
- Coinsurance, copayment, and deductible for Medicare-allowed services.

Qualified Medicare Beneficiary-Only recipients do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare. Therefore, Wisconsin Medicaid will not reimburse for services if either of the following occur:

- Medicare does not cover the service.
- The provider is not enrolled in Medicare.

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only recipients on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage was formerly known as Medicare managed care

(MMC), Medicare + Choice (MPC), or Medicare Cost (Cost). Medicare Advantage Plans have a special arrangement with the federal Centers for Medicare and Medicaid Services and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

Medicare Enrollment

Some providers may become retroactively enrolled in Medicare. Providers should contact Medicare for more information about retroactive enrollment.

Services for Dual Eligibles

As stated in HFS 106.03(6) and 106.03(7)(b), Wis. Admin. Code, a provider is required to be enrolled in Medicare if both of the following are true:

- He or she provides a Medicare Part B service to a dual eligible.
- He or she can be enrolled in Medicare.

If a provider can be enrolled in Medicare but chooses *not* to be, the provider is required to refer dual eligibles to another Medicaid provider who is enrolled in Medicare.

To receive Medicaid reimbursement for a Medicare Part B service provided to a dual eligible, a provider who is not enrolled in Medicare but can be is required to apply for retroactive enrollment.

Services for Qualified Medicare Beneficiary-Only Recipients

Because QMB-Only recipients receive coverage from Wisconsin Medicaid only for services allowed by Medicare, providers who are not enrolled in Medicare are required to refer QMB-Only recipients to another Medicaid provider who is enrolled in Medicare.

Acceptance of Assignment

In Medicare, "assignment" is a process through which a provider agrees to accept the Medicare-allowed amount as payment in full. A provider who agrees to this amount is said to "accept assignment."

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or QMB-Only recipient is required to accept assignment of the recipient's Medicare Part B benefits. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any Medicaid copayment or spenddown amounts paid by the recipient, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount.

If a provider can be enrolled in Medicare but chooses *not* to be, the provider is required to refer dual eligibles to another Medicaid provider who is enrolled in Medicare.

Claims That Do Not Require Medicare Billing

For services provided to *dual eligibles*, claims should be submitted to Wisconsin Medicaid without first submitting them to Medicare in the following situations:

- The provider cannot be enrolled in Medicare.
- The service is not allowed by Medicare under any circumstance. Providers should note that Wisconsin Medicaid denies claims for services that Medicare has determined are not medically necessary.

In these situations, providers should not indicate a Medicare disclaimer code on the claim.

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only recipient sent to Wisconsin Medicaid for payment of coinsurance, copayment, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare durable medical equipment regional carrier.
- Medicare Advantage Plan.
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier).

Types of Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to Wisconsin Medicaid.

There are two types of crossover claims based on who submits them to Wisconsin Medicaid:

- Automatic crossover claims.
- Provider-submitted crossover claims.

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to Wisconsin Medicaid.

Claims will be forwarded to Wisconsin Medicaid if the following occur:

- The provider's Medicare provider number is on file with Wisconsin Medicaid.
- The Medicare carrier has a crossover agreement with Wisconsin Medicaid.
- Medicare has identified that the services were provided to a dual eligible or a QMB-Only recipient.
- The claim is for a recipient who is not enrolled in a Medicare Advantage Plan.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is any Medicare claim that providers are allowed to submit to Wisconsin Medicaid. Providers should submit a provider-submitted crossover claim in the following situations:

- The claim is for a recipient who is enrolled in a Medicare Advantage Plan.
- The automatic crossover claim is not processed by Wisconsin Medicaid within 30 days of the Medicare processing date.
- Wisconsin Medicaid denied the automatic crossover claim and additional information may allow payment.
- The claim is for a recipient who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a recipient who was not eligible for Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the recipient was retroactively determined eligible for Wisconsin Medicaid.

Refer to Appendix 4 of this section for instructions for submitting provider-submitted crossover claims.

Claims Processed by Commercial Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental), the claim will not be forwarded to Wisconsin Medicaid. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to Wisconsin Medicaid with the appropriate other insurance indicator.

Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to Wisconsin Medicaid.

Claims That Fail to Cross Over

Claims will not cross over automatically if Wisconsin Medicaid does not have the provider's current Medicare provider number on file. Medicaid providers who submit claims to any of the intermediaries or carriers on file may submit the Provider Change of Address or Status form, HCF 1181, to update their Medicare identification numbers. Refer to the Certification and Ongoing Responsibilities section of this handbook for information about submitting the form.

Providers who have experienced problems with their claims not automatically crossing over to Wisconsin Medicaid should contact Provider Services at (800) 947-9627 or (608) 221-9883 to verify that their Medicare number is properly cross-referenced with their Medicaid identification number.

Medicaid Reimbursement for Crossover Claims

State law limits Medicaid reimbursement for coinsurance and copayment of Medicare Part B services provided to dual eligibles and QMB-Only recipients.

Total payment for a Medicare Part B service (i.e., any amount paid by other health insurance sources, any Medicaid copayment or spenddown amounts paid by the recipient, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B service is the lesser of the following:

- *Medicare*-allowed amount less any amount paid by other health insurance sources and any Medicaid copayment or spenddown amounts paid by the recipient.
- *Medicaid*-allowed amount less any amount paid by other health insurance sources and any Medicaid copayment or spenddown amounts paid by the recipient.

Refer to the following table for examples of how the limitations are applied.

Claims will not cross over automatically if Wisconsin Medicaid does not have the provider's current Medicare provider number on file.

Medicaid Reimbursement for Coinsurance or Copayment of Medicare Part B Services

Explanation	Example		
	1	2	3
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (e.g., maximum allowable fee, rate-per-visit)	$90	$110	$75
Medicare payment	$80	$80	$80
Medicaid payment	$10	$20	$0

Claims for Services Denied by Medicare

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by Wisconsin Medicaid, the provider may submit a claim for those services directly to Wisconsin Medicaid. To allow payment by Wisconsin Medicaid in this situation, providers are encouraged to follow Medicaid requirements (e.g., request prior authorization [PA] before providing the service for Medicaid-covered services that require PA). If Medicaid requirements are followed, Wisconsin Medicaid may reimburse for the service up to the Medicaid-allowed amount (less any payments made by other health insurance sources).

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles.

Medicare Disclaimer Codes

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles. Refer to claim instructions for Medicare disclaimer codes and their descriptions. The intentional misuse of Medicare disclaimer codes to obtain inappropriate reimbursement from Wisconsin Medicaid constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by Wisconsin Medicaid when Medicare benefits exist or when, for some valid reason, the provider is unable to obtain such benefits by reasonable means.

When submitting a claim for a Medicaid-covered service that was denied by Medicare, providers should resubmit the claim *directly* to Wisconsin Medicaid using the appropriate Medicare disclaimer code.

Medicare Retroactive Eligibility

If a recipient becomes retroactively eligible for Medicare, the provider is required to refund or adjust any Medicaid payments for the retroactive period. The provider is required to then bill Medicare for the services and follow Medicaid's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Provider-Based Billing

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source.

The purpose of provider-based billing is to reduce Medicaid costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to Wisconsin Medicaid. For example, a provider-based billing claim is created when Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since Medicaid benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in HFS 106.03(7), Wis. Admin. Code.

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following from Wisconsin Medicaid:

- A notification letter.
- A Provider-Based Billing Summary. The Summary lists each Medicaid claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim.
- Provider-based billing claim(s). For each Medicaid claim indicated on the Provider-Based Billing Summary, the provider will receive a prepared provider-based billing claim. This claim may be used to bill the other health insurance source; the claim includes all of the other health insurance source's information that is available from Wisconsin Medicaid.

If a recipient has coverage through multiple other health insurance sources, the provider may receive additional Provider-Based Billing Summaries and provider-based billing claims for each other health insurance source that is on file with Wisconsin Medicaid.

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider may use the claim prepared by Wisconsin Medicaid or produce his or her own claim. If the other health insurance source requires information beyond what is indicated on the prepared claim, the provider should add that information to the claim. The providers should also attach additional documentation (e.g., Medicare's remittance information) if required by the other health insurance source.

Responding to Wisconsin Medicaid

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the Medicaid Eligibility Verification System that Wisconsin Medicaid has removed or enddated the other health insurance coverage from the recipient's file.
- The provider verifies that the recipient's other coverage information reported by Wisconsin Medicaid is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial *and* follow-up provider-based billing claim.

Detailed instructions for responding to Wisconsin Medicaid about provider-based billing claims are included in Appendix 5 of this section.

If the provider's response to Wisconsin Medicaid does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

If a response is not received within 120 days, the amount originally paid by Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive Medicaid payment after the original Medicaid payment has been withheld, the provider is required to submit one of the following:

- A new claim for dates of service (DOS) that are within claims submission deadlines. Providers should follow normal claims submission procedures.
- A timely filing appeals request for DOS that are beyond claims submission deadlines. Providers should follow normal timely filing appeals procedures.

Instructions for responding to Wisconsin Medicaid about provider-based billing claims that are beyond the 120-day limit are included in Appendix 5 of this section.

For More Information

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at (608) 221-4746, ext. 3142. Providers may fax the corresponding Provider-Based Billing Summary to (608) 221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are *not* within the 120-day limit, providers may call Provider Services at (800) 947-9627 or (608) 221-9883.

If a response is not received within 120 days, the amount originally paid by Wisconsin Medicaid will be withheld from future payments.

Reimbursement for Accident Victims

As stated in HFS 106.03(8), Wis. Admin. Code, Wisconsin Medicaid will not reimburse providers if they receive payment from:

- Civil liabilities (e.g., injuries from an automobile accident).
- Worker's compensation.

Refunding Medicaid payment and then seeking payment from a settlement may constitute a felony.

Providers may choose to seek payment from worker's compensation or civil liabilities. Providers may receive more than the Medicaid-allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Providers are not required to seek payment from worker's compensation or civil liabilities, instead of Wisconsin Medicaid, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Billing Options

When providing services to an accident victim, the provider may proceed in one of the following ways:

- The provider may seek payment from the liability settlement. After selecting this option, the provider may *instead* submit the claim to Wisconsin Medicaid as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to Wisconsin Medicaid because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.
- The provider may submit the claim to Wisconsin Medicaid. If the provider selects this option, he or she may *not* seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to Wisconsin Medicaid, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding Medicaid payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, Wisconsin Medicaid retains the sole right to recover medical costs.

Providers are required to indicate when services are provided to an accident victim on claims submitted to Wisconsin Medicaid. If the recipient has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to Wisconsin Medicaid.

The provider may choose a different option for each date of service. For example, the decision to submit one claim to Wisconsin Medicaid does not mean that all claims pertaining to the recipient's accident must be submitted to Wisconsin Medicaid.

A Medicaid-certified provider may not collect payment from a recipient, or authorized person acting on behalf of the recipient, for Medicaid-covered services even if the services are covered but do not meet program requirements (including, but not limited to, submitting claims before the claims submission deadline).

Appendix

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Appendix 1
Services Requiring Other Health Insurance Billing

If the Medicaid Eligibility Verification System (EVS) indicates the code **"DEN"** for "Other Coverage," the provider is required to bill dental services to commercial health insurance before submitting claims to Wisconsin Medicaid. Refer to service-specific publications for information about dental insurance.

If the EVS indicates that the recipient has Wausau Health Protection Plan (**"HPP"**), BlueCross & BlueShield (**"BLU"**), Wisconsin Physicians Service (**"WPS"**), TriCare (**"CHA"**), or some other (**"OTH"**) commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to Wisconsin Medicaid:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or skilled nursing facility (SNF).
- Blood bank services.
- Chiropractic services.
- Community support program services.
- Dental services. Refer to service-specific publications for information about billing commercial health insurance or dental insurance for dental services.
- Durable medical equipment (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding personal care services [PCS]).
- Hospice services.
- Hospital services, including inpatient or outpatient.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services for recipients who have Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of place of service (POS).
- Physical therapy, occupational therapy (OT), and speech and language pathology (SLP) services, unless provided in a nursing home or SNF.
- Physician assistant services.
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient. However, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing.
- Pharmacy services for recipients with verified drug coverage.
- Podiatry services.
- Radiology services.
- Respiratory care services.
- Rural health clinic services.
- Skilled nursing home care, if any date of service (DOS) is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over $50, unless provided in a home, nursing home, or SNF.

Appendix 1
(Continued)

If the EVS indicates the code **"VIS"** for "Other Coverage," the provider is required to bill the following services to commercial health insurance before submitting claims to Wisconsin Medicaid:

- Ophthalmology services.
- Optometrist services.

If the EVS indicates the code **"HMO"** for "Other Coverage," the provider is required to bill the following services to commercial health insurance before submitting claims to Wisconsin Medicaid:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF.
- Blood bank services.
- Chiropractic services.
- Community support program services.
- Dental services. Refer to service-specific publications for information about billing commercial health insurance or dental insurance for dental services.
- Durable medical equipment (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PCS).
- Hospice services.
- Hospital services, including inpatient or outpatient regardless of the type of hospital.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services billed for a recipient who has both Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- Pharmacy services for recipients with verified drug coverage.
- Physical therapy, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician and physician assistant services.
- Podiatry services.
- Radiology services.
- Respiratory care services.
- Rural health clinic services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over $50, unless provided in a home, nursing home, or SNF.

Appendix 1
(Continued)

If the EVS indicates Medicare Supplemental Plan Coverage (**"SUP"**), the provider is required to bill the following services to commercial health insurance before submitting claims to Wisconsin Medicaid:

- Alcohol, betadine, and/or iodine provided by a pharmacy or medical vendor.
- Ambulance services.
- Ambulatory service center services.
- Breast reconstruction services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PCS).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.
- Skilled nursing home care, if any DOS is within 100 days of the date of admission. If benefits greater than 100 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.

If the EVS indicates Medicare + Choice (**"MPC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to Wisconsin Medicaid:

- Ambulance services.
- Ambulatory service center services.
- Chiropractic services.
- Dental anesthesia services
- Home health services (excluding PCS).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.

If the EVS indicates Medicare Cost (**"MCC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to Wisconsin Medicaid:

- Ambulance services.
- Home health services (excluding PCS).
- Medicare-covered services.

Appendix 2
Other Coverage Discrepancy Report
(for photocopying)

(A copy of the Other Coverage Discrepancy Report form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1159 (Rev. 08/05)

WISCONSIN MEDICAID
OTHER COVERAGE DISCREPANCY REPORT

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary; providers may develop their own form as long as it includes all the information on this form. Attach additional pages if more space is needed.

INSTRUCTIONS: Use this form to notify Wisconsin Medicaid of discrepancies between other health care coverage information obtained through the Medicaid Eligibility Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. Wisconsin Medicaid will verify the information provided and update the recipient's file (if applicable). Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.

SECTION I — PROVIDER AND RECIPIENT INFORMATION

Name — Provider (Last, First, Middle Initial)	Wisconsin Medicaid Provider Number	
Name — Recipient (Last, First, Middle Initial)	Date of Birth — Recipient	Recipient Medicaid Identification Number

SECTION II — MEDICARE PART A AND B COVERAGE

Recipient Medicare / HIC Number

❑ Add		❑ Remove	
❑ Part A Coverage	Start Date	❑ Part A Coverage	End Date
❑ Part B Coverage	Start Date	❑ Part B Coverage	End Date

SECTION III — COMMERCIAL HEALTH INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

❑ Add	❑ HMO	❑ Medicare Managed Care
❑ Remove	❑ Medicare Supplement	❑ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, Zip Code)

Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date

Recipient Left HMO Service Area ❑ Yes ❑ No	Date Recipient Left HMO Service Area (If Applicable)

SECTION IV — REPORT INFORMATION

Name — Individual Completing This Report	Date Signed	Telephone Number / Extension
Name — Source of Information Included on This Report		Telephone Number / Extension

Mail to	Fax to	Comments
Wisconsin Medicaid Coordination of Benefits 6406 Bridge Rd Madison WI 53784-6220	Coordination of Benefits (608) 221-4567	(Attach additional pages if necessary.)

Appendix 3

Claims Submission Procedures for Recipients with Commercial Health Insurance Coverage

Providers are required to exhaust commercial health insurance sources before submitting claims to Wisconsin Medicaid. This is accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Step 1. Determine if the Recipient Has Commercial Health Insurance

If the Medicaid Eligibility Verification System (EVS) does not indicate that the recipient has commercial health insurance, the provider may submit a claim to Wisconsin Medicaid unless the provider is otherwise aware of commercial health insurance coverage.

If the recipient disputes the information as it is indicated in the EVS, the provider should submit a completed Other Coverage Discrepancy Report form, HCF 1159, to Wisconsin Medicaid. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

Step 2. Determine if the Service Requires Other Health Insurance Billing

If the service requires other health insurance billing (according to Appendix 1 of this section), the provider should proceed to Step 3.

If the service does not require other health insurance billing (according to Appendix 1 of this section), the provider should proceed in one of the following ways:

- The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.
- The provider may submit a claim to Wisconsin Medicaid without indicating an other insurance indicator on the claim.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with Wisconsin Medicaid's ability to recover prior payments.

Step 3. Identify Assignment of Commercial Health Insurance Benefits

The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the recipient for this assignment of benefits.)

The provider should proceed in one of the following ways:

- **If the provider is assigned benefits**, the provider should bill commercial health insurance and proceed to Step 4.
- **If the recipient is assigned insurance benefits**, the provider may submit a claim to Wisconsin Medicaid (without billing commercial health insurance) using the appropriate other insurance indicator.

If the commercial health insurance reimburses the recipient, the provider may collect the payment from the recipient. If the provider receives reimbursement from Wisconsin Medicaid and the recipient, the provider is required to return the lesser amount to Wisconsin Medicaid.

(continued on next page)

Step 4. Bill Commercial Health Insurance and Follow Up
If commercial health insurance denies or partially reimburses the provider for the claim, the provider may proceed to Step 5. **If commercial health insurance does not respond within 45 days,** the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

Step 5. Submit Claim to Wisconsin Medicaid
If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to Wisconsin Medicaid using the appropriate other insurance indicator. Commercial remittance information should not be attached to the claim.

Appendix 4

Claims Submission Procedures for Dual Eligibles and Qualified Medicare Beneficiary-Only Recipients

Providers are required to exhaust Medicare coverage before submitting claims to Wisconsin Medicaid. This is accomplished by following the instructions in this appendix. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim.

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request, HCF 13046, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.) The provider should refer to the Claims Information section of this handbook for information about submitting adjustment requests.

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- The claim is for a recipient who is enrolled in a Medicare Advantage Plan.
- The automatic crossover claim is not processed by Wisconsin Medicaid within 30 days of the Medicare processing date.
- Wisconsin Medicaid denied the automatic crossover claim and additional information may allow payment.
- The claim is for a recipient who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a recipient who was not eligible for Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the recipient was retroactively determined eligible for Wisconsin Medicaid.*

When submitting provider-submitted crossover claims, the provider is required to follow all Medicaid claims submission requirements in addition to the following:

- For electronic claims, indicate the Medicare payment.
- For paper claims, the provider is required to the do the following:
  - ✓ Attach Medicare's remittance information and refrain from indicating the Medicare payment.
  - ✓ Indicate "MMC" in the upper right corner of the claim for services provided to recipients enrolled in a Medicare Advantage Plan.

When submitting provider-submitted crossover claims for recipients enrolled in Medicare and commercial health insurance that is secondary to Medicare, the provider is also required to do the following:

- Refrain from submitting the claim to Wisconsin Medicaid until after the claim has been processed by the commercial health insurance.
- Indicate the appropriate other insurance indicator.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive eligibility" on the provider-submitted crossover claim and submit the claim with the Timely Filing Appeals Request form, HCF 13047. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated eligibility was added to the recipient's file.

Claim for Services Denied by Medicare

When Medicare denies payment for a service provided to a dual eligible that is covered by Wisconsin Medicaid, the provider may proceed as follows:

- Bill commercial health insurance, if applicable.
- Submit a claim to Wisconsin Medicaid using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed as a Medicaid Claim

A crossover claim may have been previously reimbursed as a Medicaid claim when one of the following occurs:

- Medicare reconsiders services that were previously not allowed.
- Medicare retroactively determines a recipient eligible.

In these situations, the provider is should proceed as follows:

- Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.
- Bill Medicare for the services and follow Medicaid's procedures for submitting crossover claims.

Appendix 5

Procedures for Responding to Wisconsin Medicaid About Provider-Based Billing Claims

When responding to Wisconsin Medicaid about provider-based billing claims, providers are required to submit the required documentation to the appropriate address as indicated in the following table.

Within 120-Day Limit		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the Medicaid Eligibility Verification System (EVS) that Wisconsin Medicaid has removed or enddated the other health insurance coverage from the recipient's file.	• The Provider-Based Billing Summary. • Indication that the EVS no longer reports the recipient's other coverage.	Wisconsin Medicaid Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The provider discovers that the recipient's other coverage information (i.e., eligibility dates) reported by the EVS is invalid.	• The Provider-Based Billing Summary. • One of the following: ✓ The name of the person with whom the provider spoke and the recipient's correct other coverage information. ✓ A printed page from an eligibility Web site containing the recipient's correct other coverage information.	Wisconsin Medicaid Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The date of service (DOS), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. *Note:* In this situation, Wisconsin Medicaid will initiate an adjustment if the amount of the other health insurance payment does not exceed the Medicaid-allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	Wisconsin Medicaid Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source denies the provider-based billing claim.	• The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: ✓ Remittance information from the other health insurance source. ✓ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ✓ Documentation indicating that the other health insurance source paid the recipient. ✓ A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	Wisconsin Medicaid Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source fails to respond to the initial *and* follow-up provider-based billing claim.	• The Provider-Based Billing Summary. • Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	Wisconsin Medicaid Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

Appendix 5
(Continued)

Beyond 120-Day Limit but Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that Wisconsin Medicaid has removed or enddated the other health insurance coverage from the recipient's file.	A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim).	Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The provider discovers that the recipient's other coverage information (i.e., eligibility dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form, HCF 1159. • A claim according to normal claims submission procedures *after* verifying that the recipient's other coverage information has been updated by using the EVS (do *not* use the prepared provider-based billing claim).	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following: Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

Appendix 5
(Continued)

Beyond 120-Day Limit and Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that Wisconsin Medicaid has removed or enddated the other health insurance coverage from the recipient's file.	• A claim (do *not* use the prepared provider-based billing claim). • A Timely Filing Appeals Request form, HCF 13047, according to normal timely filing appeals procedures.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The provider discovers that the recipient's other coverage information (i.e., eligibility dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form. • *After* using the EVS to verify that the recipient's other coverage information has been updated, include both of the following: ✓ A claim (do *not* use the prepared provider-based billing claim.) ✓ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following: Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The other health insurance source denies the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: ✓ Remittance information from the other health insurance source. ✓ A written statement from the other health insurance source identifying the reason for denial. ✓ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ✓ Documentation indicating that the other health insurance source paid the recipient. ✓ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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Index