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# Preface

The Wisconsin Medicaid Personal Care Handbook is issued to personal care providers who participate in Wisconsin Medicaid. It contains information that applies to *fee-for-service* Medicaid providers. The information in this handbook applies to services provided to both Medicaid and BadgerCare recipients.

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 below 185% 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.

Medicaid and BadgerCare recipients enrolled in Medicaid HMOs are entitled to at least the same benefits as Medicaid fee-for-service recipients; however, HMOs may establish their own requirements regarding coverage limitations, prior authorization, billing, etc. If you are a Medicaid HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used to resolve disputes regarding covered benefits under managed care arrangements.

The Personal Care Handbook consists of the following sections:

- General Information.
- Covered Services.
- Prior Authorization.
- Billing.

In addition to the Personal Care Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following subjects:

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

The Provider Rights and Responsibilities section of the All-Provider Handbook identifies specific responsibilities of a Wisconsin Medicaid provider. Refer to this section for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

## **Important:**

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

### *Wisconsin regulation and law*

- Regulation: Wisconsin Administrative Code, Rules of Health and Family Services, Chapters HFS 101 - 108.
- Law: Wisconsin Statutes: Sections 49.43 - 49.497 and 49.665.

### *Federal regulation and law*

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

Wisconsin Medicaid handbooks and updates further interpret and implement these laws and regulations.

Wisconsin Medicaid handbooks and updates, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information are available at Wisconsin Medicaid's web site at: [www.dhfs.state.wi.us/medicaid](http://www.dhfs.state.wi.us/medicaid).

The DHFS contracts with a fiscal agent to provide health claims processing, communications, and other related services.

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# Coordination of Benefits

## Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for any services covered by Wisconsin Medicaid according to HFS 106.03(7)(b), Wis. Admin. Code. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of its maximum allowable fee remaining after exhausting all other health insurance sources. Refer to the All-Provider Handbook for more detailed information on services requiring health insurance billing, cases in which providers should bill Wisconsin Medicaid *before* billing other forms of insurance, and the “Other Coverage Discrepancy Report (TPL-17).”

## Medicare/Medicaid Dual Entitlement

### General Information

Recipients covered under both Medicare and Medicaid are called dual entitlements.

Although services covered by Medicare do not require prior authorization (PA) from Wisconsin Medicaid, providers are strongly encouraged to obtain authorization prior to providing services. This will ensure Wisconsin Medicaid payment if Medicare denies coverage or if services exceed Medicare coverage.

### Personal Care Services

If a recipient qualifies for Medicare home health services, Medicare will reimburse for a home health aide to provide hands-on personal care (e.g., bathing, dressing, grooming, and transfers) to maintain the recipient’s health or facilitate treatment of the recipient’s illness or injury. Agencies that Wisconsin Medicaid certifies to provide both home health and personal care services and personal care-only agencies follow different procedures regarding dual entitlements.

### Home Health/Personal Care Agencies

If the recipient is a dual entitlement and Medicare covers the service, Medicare-enrolled providers are required to send claims to Medicare *before* billing Wisconsin Medicaid, according to HFS 106.03(7)(b), Wis. Admin. Code.

If Medicare covers the service provided to a dual entitlement but the claim is denied, Medicare-enrolled providers should indicate a Medicare disclaimer code in the appropriate field/item on the Wisconsin Medicaid claim form. Claims denied by Medicare due to provider billing error must be corrected and resubmitted to Medicare before being sent to Wisconsin Medicaid. Refer to Item 84 of the UB-92 Claim Form Instructions in Appendix 2 of this section for the appropriate Medicare disclaimer code.

### Personal Care-Only Agencies

Wisconsin Medicaid will not reimburse for personal care services which would be reimbursed by Medicare. Personal care-only agencies are not Medicare-enrolled providers. Therefore, they are required to notify all personal care recipients about Medicare coverage and:

- Provide the recipient with the “Notice to Wisconsin Medicaid Recipients Regarding This Personal Care Agency” form. Refer to Appendix 1 of this section for this form.
- Have the recipient or legally responsible person review and sign this form.
- Give the recipient a copy and keep the original form in the recipient’s file.

If the recipient is eligible for Medicare home health services and your agency is not enrolled by Medicare to provide home health services, you are required to either:

- Coordinate care with a Medicare-enrolled home health agency so your agency

Wisconsin Medicaid is the payer of last resort for any services covered by Wisconsin Medicaid.

provides only those personal care hours that exceed Medicare's home health coverage.

- Discharge the recipient from your care.

### Disposable Medical Supplies

Medicare may pay for disposable medical supplies (DMS) under Part B coverage. Medicare-enrolled providers are required to bill Medicare for these supplies. If you are not certified to bill Medicare, the recipient will need to obtain the supplies from a different Medicare-enrolled provider, such as a rehabilitation agency, pharmacy, or other medical equipment or supplies vendor.

If a provider submits claims to Wisconsin Medicaid for services that Medicare would pay, Wisconsin Medicaid may recoup any related payments it made on a postpayment basis.

### Use Coverage Determination Software to Ensure Appropriate Billing

All Medicaid-certified home health and personal care providers receive coverage determination software (CDS) upon certification and are required to use it for recipients who are eligible for both Medicare and Wisconsin Medicaid. This computer software helps providers identify when they should bill Medicare before billing Wisconsin Medicaid for dual entitlements. It also allows you to access help screens which explain Medicare home health policy. The printed results from the CDS determination provide documentation to meet the federal requirement that services covered by Medicare are not paid by Wisconsin Medicaid.

Requirements for the use of CDS for recipients who are entitled to both Medicare and Wisconsin Medicaid are reviewed below:

- Use the CDS before your agency provides Wisconsin Medicaid services.
- Use the CDS when a recipient's condition or status changes, potentially making the

recipient eligible for Medicare home health coverage.

- Keep a printed copy of the results of the software's determination on file and on the agency's premises for audit purposes.

If you are unable to access the CDS with your computer system or have computer problems, you can use the Worksheet for Home Health Coverage Determination Questions from the CDS Manual to reach the same results. Photocopy the final eligibility determination from Appendix B of the CDS Manual for your files.

Technical questions about the software should be directed to:

United Wisconsin Proservices, Inc.  
401 W. Michigan Street  
Milwaukee, WI 53202

Telephone: (800) 822-8050  
Fax: (414) 226-6033

Policy and billing questions should be directed to:

Medicaid Provider Services  
(800) 947-9627 or (608) 221-9883

### Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary-Only (QMB-Only) and Qualified Medicare Beneficiary-Nursing Home (QMB-NH) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. If Medicare denies services, Wisconsin Medicaid does not cover them.

Refer to the All-Provider Handbook for more information on QMB-Only recipients.

All Medicaid-certified home health and personal care providers receive coverage determination software (CDS) upon certification and are required to use it for recipients who are eligible for both Medicare and Wisconsin Medicaid.

# Billed Amounts

Providers are required to bill for each date of service that care was provided.

Providers are required to bill their usual and customary charge for services provided. Refer to the General Information section of this handbook for more information on reimbursement.

## Billing Dates of Service

Providers are required to bill for each date of service that care was provided. When billing, a maximum of four dates of service may be entered on one detail line, given the following conditions:

- All dates of service are in the same calendar month.
- Procedure codes are the same for all four dates of service.
- The charges for the procedures are identical for each date of service.
- The quantity of units is the same for all dates of service.

The quantity entered for each detail line represents the number of units for each day, multiplied by the number of days of service. Similarly, the charges for each detail line represent the charges for that service multiplied by the number of days of service. Refer to Appendix 3 of this section for an example of series billing.

If two or more detail lines must be used for the same procedure/revenue code (e.g., when billing more than four identical dates of service in a calendar month), the additional dates of service that can be billed to the same procedure/revenue code must be indicated on a separate detail line. The appropriate units and charges for those dates of service must also be included.

Each detail line must always include the correct units and charges for the dates on that line or the claim will be denied.

## Billing Units of Service

### Personal Care and Travel Time

For personal care services and travel time, one hour of service is equivalent to one unit of service and one-half hour of service is equivalent to one-half unit of service. Personal care providers should bill in one-half hour increments.

When calculating the number of units that should be billed (Item 46 on the UB-92 claim form), total the number of personal care hours or travel time hours for that date of service, and round up or down according to the following guidelines:

- If the time spent giving care is a maximum of 1 to 30 minutes in length, round the time up to 30 minutes and bill the service as a quantity of 0.5 unit.
- If the time spent giving care is more than 30 minutes in length, then round up or down to the nearest 30-minute increment using the common rules of rounding.

Follow the same rounding rules when calculating travel time. Refer to Appendix 4 for a chart of rounding guidelines. Refer to the Covered Services chapter of the Covered Services section of this handbook for more information on travel time.

### Registered Nurse Supervisory Visits

Registered nurse supervisory visits for personal care (procedure codes W9906 or W9044) must be billed as a quantity of one unit, regardless of the duration of the visit. For example, a supervisory visit lasting 20 minutes and a supervisory visit lasting 60 minutes would both be billed a quantity of 1. Refer to the Covered Services section of this handbook for more information on personal care supervisory visits.



## Procedure Codes

### All Personal Care Services

Providers are required to use Wisconsin Medicaid procedure codes (W codes) to bill personal care services, travel time and RN supervisory visits. Refer to Appendix 4 for a current list of allowable procedure codes and descriptions. Claims or adjustments received without the appropriate codes are denied.

### Disposable Medical Supplies

Providers are required to use the HCFA Common Procedure Coding System (HCPCS) codes for billing disposable medical supplies (DMS). Covered DMS codes can be found in the DMS Index, which is sent to providers periodically, or on the Wisconsin Medicaid web site at [www.dhfs.state.wi.us/medicaid](http://www.dhfs.state.wi.us/medicaid). Claims or adjustments received without the appropriate codes are denied.

## Billing Place of Service and Type of Service on Claim Form

### UB-92 Claim Form

Personal care services are billed on the UB-92 claim form. Place of service (POS) and type of service (TOS) codes are not required. However, providers should keep in mind that place of service and type of service codes are required on the Prior Authorization Request Form (PA/RF), elements 16 and 17.

### HCFA 1500 Claim Form

Use the HCFA 1500 claim form to bill DMS. Both place of service and type of service codes are required. Refer to Appendix 4 for allowable place of service and allowable type of service codes.



Providers are required to use Wisconsin Medicaid procedure codes (W codes) to bill personal care services, travel time and RN supervisory visits.

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# Guidelines for Billing Services

Prior authorization does not guarantee reimbursement.

## Billing for Personal Care and Travel Time Services Not Prior Authorized

Wisconsin Medicaid allows Medicaid-certified providers to be reimbursed for the first 50 hours of medically necessary personal care and travel time services per calendar year, per recipient in any combination of prior authorized or non-prior authorized hours. All prior authorized and non-prior authorized services reimbursed in the calendar year, regardless of date of service or when the claim is submitted, count toward this 50-hour threshold. Therefore, providers should take care to delay submitting claims for prior authorized personal care hours until *after* claims for non-authorized hours have been finalized.

Providers should bill all personal care and travel time services without prior authorization (PA) on a separate claim form from those services with PA.

## Billing for Prior Authorized Services

Prior authorization does not guarantee reimbursement. Provider certification, recipient eligibility, and medical necessity, as well as all other state and federal requirements, must be met before the claim is paid, according to HFS 107.02(3)(i), Wis. Admin. Code.

Listed below are some guidelines for billing Wisconsin Medicaid prior authorized services:

- The PA number indicated on the Prior Authorization Request Form (PA/RF) must be on all claims for dates of service that are between the grant date and expiration date of the approved PA/RF.
- Reimbursement will be allowed only for direct care or travel hours actually used, within rounding guidelines, even if the PA allows for additional time.
- Reimbursement will be allowed only for dates of service between the grant date and expiration date indicated on the approved PA/RF.
- Only one PA number is allowed per claim form. Services authorized under separate PA requests should be billed on separate claim forms.
- Medicaid-certified home health/personal care agencies can bill for both home health and personal care services on the same claim form if the corresponding PA includes both personal care worker and home health procedure codes.

## Billing for Multiple Recipients in a Single Location

If personal care services are provided to more than one recipient at a single location, providers should only bill for the actual time spent by the PCW (rounded to the nearest 30-minute increment). Billing examples follow:

- *Services performed in sequence.* If you are providing bathing and dressing services to a husband and wife in the same home, bill separately for the actual time spent (within rounding guidelines) providing services for each recipient. The total time billed cannot exceed the actual time spent giving care, within rounding guidelines.
- *Services performed simultaneously.* Bill only once for tasks that are simultaneously performed for more than one recipient at a time. Examples include cleaning, laundry, grocery shopping, meal preparation, and travel time.
  - ✓ Housekeeping example: If it takes two hours to provide cleaning, laundry, and meal preparation for a husband and wife who are both Wisconsin Medicaid recipients and live in the same home, bill Medicaid one hour for the husband and one hour for the wife. Billing two hours for each recipient is

duplicate billing and would be subject to recoupment.

- √ Travel time example: If you are providing personal care services for two recipients residing in a Community Based Residential Facility (CBRF), add your travel time to and from the CBRF, round to the nearest 30-minute increment, and bill for one recipient only. Billing the total travel time to each recipient is duplicate billing and would be subject to recoupment. Refer back to the Billing Units of Service portion of this section for more information.

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# Community Services Deficit Reduction Benefit

Eligible agencies wishing to participate in the Community Services Deficit Reduction Benefit (CSDRB) program must submit completed certification forms and cost reports developed by the Department of Health and Family Services (DHFS).

Wisconsin Statutes authorize Wisconsin Medicaid to make federal financial participation funds (FFP) available to counties, local health departments, and tribal agencies to reimburse these agencies for operating deficits incurred in providing personal care and selected other non-institutional services to Wisconsin Medicaid recipients. Operating deficits are defined as the difference between program costs and the Wisconsin Medicaid claims paid amount (after certain adjustments).

Eligible agencies wishing to participate in the Community Services Deficit Reduction Benefit (CSDRB) program must submit completed certification forms and cost reports developed by the Department of Health and Family Services (DHFS). Costs reported by participating agencies must be based on allowable cost and cost-finding principles as instructed by the DHFS. These costs are evaluated by the DHFS for reasonableness and accuracy. Benefits are paid retroactively based on information provided in the cost reports, subject to DHFS review and limitations.

For information on this program or to send in completed certification forms and cost reports, contact the CSDRB coordinator at:

CSDRB Coordinator  
10 East Doty Street  
Suite 210  
Madison, WI 53703  
(888) 322-1006

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# Claims Submission

Each Medicaid-certified provider is responsible for the truthfulness, accuracy, timeliness, and completeness of claims whether billing Wisconsin Medicaid themselves or through a billing service.

Providers using a billing service should provide Wisconsin Medicaid instructions to the billing service. Always provide the billing service an accurate list of the hours and dates of service provided. Each Medicaid-certified provider is responsible for the truthfulness, accuracy, timeliness, and completeness of claims whether billing Wisconsin Medicaid themselves or through a billing service, according to HFS 106.02(9)(e), Wis. Admin. Code. Claims may be submitted on paper or electronically.

## Paper Claims

### Personal Care Services

Providers are required to use the UB-92 claim form when submitting paper claims to Wisconsin Medicaid. Personal care claims submitted on paper claim forms other than the UB-92 will be denied. Refer to appendices 2 and 3 of this section for UB-92 completion instructions and for an example of a UB-92 claim form.

### Disposable Medical Supplies

Disposable medical supplies (DMS) provided by personal care providers must be billed on the HCFA 1500 claim form using the HCFA Common Procedure Coding System. Wisconsin Medicaid provides the DMS Index to all Medicaid-certified personal care providers. Refer to the DMS Index for procedure codes and coverage limitations. Wisconsin Medicaid denies DMS claims that are submitted on any form other than the HCFA 1500 claim form. Refer to appendices 5 and 6 for HCFA 1500 completion instructions for DMS and for an example of a HCFA 1500 claim form for DMS.

### Obtaining UB-92 and HCFA 1500 Forms

Wisconsin Medicaid does not supply the UB-92 or HCFA 1500 claim forms. They may be obtained from a number of commercial form

suppliers. One such source is the Standard Register, which can be contacted at:

Standard Register  
P.O. Box 6248  
Madison, WI 53716  
(608) 222-4131

### Submitting Claims

Completed UB-92 and HCFA 1500 claim forms should be mailed to:

Wisconsin Medicaid  
6406 Bridge Road  
Madison, WI 53784-0002

## Electronic Claim Forms

Both the UB-92 and HCFA 1500 claim forms are available in electronic formats. Wisconsin Medicaid provides free software for billing claims electronically. If you currently use the free PACE or EZ-Link electronic billing software and have technical questions, please contact the United Wisconsin Proservices, Inc. customer service desk at (800) 822-8050.

For policy questions, contact Provider Services at (800) 947-9627 or (608) 221-9883. For data entry questions within the software, contact the Electronic Media Claims (EMC) unit at (608) 221-4746, Ext. 3037 or 3041.

Electronic claim submission eliminates manual handling of claims, reducing errors and allowing faster turn-around time. As with paper claims, electronically submitted claims can be processed and paid correctly only if all data supplied is accurate and complete. Providers are responsible for the accuracy of all data submitted via electronic claims.

For more information on electronic claims, refer to the All-Provider Handbook, or contact

the Electronic Media Claims (EMC) department at:

EMC Department  
Wisconsin Medicaid  
6406 Bridge Road  
Madison, WI 53784-0009  
(608) 221-4746, Ext. 3037 or 3041

## Follow-up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid, according to HFS 106.03(3)(b)2, Wis. Admin. Code.

Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Refer to Appendix 7 for a partial list of Explanation of Benefit codes (denial codes) and how to avoid common claim denials.

Wisconsin Medicaid takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to Wisconsin Medicaid. Refer to the All-Provider Handbook for detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good Faith claims filing procedures.

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid.

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# Appendix

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## Appendix 1

### Notice to Wisconsin Medicaid Recipients Regarding This Personal Care Agency

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Name of Personal Care Agency

is paid by Wisconsin Medicaid for personal care. This agency is not Medicare-certified and so Medicare does not pay this agency for personal care. Wisconsin Medicaid will not pay this agency for personal care for any patient who is eligible for these services under Medicare.

By signing below, I am saying I understand that:

- If I become eligible for personal care services under Medicare, Wisconsin Medicaid will not pay this agency for my personal care unless this agency shares my care with another agency that can be paid by Medicare.
- If this agency does not share my care with another agency that can be paid by Medicare, this agency will discharge me so that I can receive care from another agency that can be paid by Medicare.
- This agency cannot bill me personally for personal care or any other service covered under Medicare or Wisconsin Medicaid.
- If I have questions regarding this policy, I can call Wisconsin Medicaid Recipient Services at (800) 362-3002 or (608) 221-5720.

---

Wisconsin Medicaid Recipient Signature or  
Person Legally Responsible for Recipient

Date

\* \* \*

By signing below, the registered nurse (RN) who supervises this recipient's personal care worker verifies that if this recipient was unable to read the form, the RN read it to the recipient.

---

Registered Nurse Signature

Date

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## Appendix 2

### UB-92 Claim Form Instructions

Use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless “not required” is specified.

These instructions will help you complete a UB-92 claim only for Wisconsin Medicaid. For complete billing instructions, refer to the UB-92 Billing Manual prepared by the State Unified Billing Committee (SUB-C). The UB-92 Billing Manual contains important coding information not available in this appendix. You may purchase the UB-92 Billing Manual by writing to:

Wisconsin Health and Hospital Association  
5721 Odana Road  
Madison, Wisconsin 53719-1289  
(608) 274-1820

Wisconsin Medicaid recipients receive a plastic identification card (the Forward card) when initially enrolled in Wisconsin Medicaid. Always see this card before providing services. Please use the information exactly as it appears on the ID card to complete the patient information.

#### **Item 1: Provider Name, Address, and Telephone Number**

Enter the name, address, city, state and ZIP code of the billing provider.

#### **Item 2: Unlabeled Field (not required)**

#### **Item 3: Patient Control Number (not required)**

Providers may enter the patient's internal office account number. This number will appear on the Wisconsin Medicaid fiscal agent Remittance and Status Report (maximum of 17 characters for paper, electronic, or tape claims).

#### **Item 4: Type of Bill**

Enter the 3-digit code indicating the specific type of claim. The first digit identifies the type of facility. The second digit classifies the type of care. Personal care/home health providers are required to use bill type 33X. The third digit (“X”) indicates the billing frequency and should be assigned as follows (331, 332, 333, or 334):

- 1 = Inpatient admit through discharge claim
- 2 = Interim bill - first claim
- 3 = Interim bill - continuing claim
- 4 = Interim bill - final claim

#### **Item 5: Federal Tax Number (not required)**

#### **Item 6: Statement Covers Period (from - through) (not required)**

#### **Item 7: Covered Days (not required)**

#### **Item 8: Noncovered Days (not required)**

#### **Item 9: Coinsurance Days (not required)**

#### **Item 10: Lifetime Reserve Days (not required)**

Appendix 2  
(cont.)

**Item 11: Unlabeled Field** (not required)

**Item 12: Patient Name**

Enter the recipient's last name, first name, and middle initial exactly as it appears on the plastic Wisconsin Medicaid identification card (the Forward card), including spaces and hyphens.

**Item 13: Patient's Address** (not required)

**Item 14: Patient's Date of Birth** (not required)

**Item 15: Patient's Sex** (not required)

**Item 16: Marital Status** (not required)

**Item 17: Date of Admission** (not required)

**Item 18: Hour of Admission** (not required)

**Item 19: Type of Admission** (not required)

**Item 20: Source of Admission** (not required)

**Item 21: Discharge Hour** (not required)

**Item 22: Patient Status** (not required)

**Item 23: Medical/Health Record Number** (optional)

This number will not appear on the Remittance and Status Report.

**Items 24-30: Condition Codes** (Required, if applicable.)

Code	Explanation of Code
01	<i>Military service related:</i> Medical condition incurred during military service.
02	<i>Condition is employment related:</i> Patient alleges that medical condition is due to environment/events resulting from employment.
03	<i>Recipient covered by insurance not reflected here:</i> Indicates that the patient or a representative has stated that coverage may exist beyond that reflected on this bill.
05	<i>Lien has been filed:</i> Provider has filed legal claim for recovery of funds potentially due a recipient as a result of legal action initiated by or on behalf of the patient.
08	<i>Beneficiary would not provide information concerning other insurance coverage:</i> Enter this code if the beneficiary would not provide information concerning other insurance coverage.

See UB-92 Billing Manual for additional codes.

**Items 32-35(a-b): Occurrence Codes and Dates** (Required, if applicable.)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates are required to be printed in the MMDDYY format.

## Appendix 2 (cont.)

Code	Explanation of Code
01	<i>Auto Accident:</i> Code indicating the date of an auto accident.
02	<i>Auto Accident/No Fault Insurance:</i> Code indicating the date of an auto accident where the state has applicable no-fault liability laws.
03	<i>Accident/Tort Liability:</i> Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	<i>Accident/Employment Related:</i> Code indicating the date of an accident relating to the patient's employment.
05	<i>Other Accident:</i> Code indicating the date of an accident not described by the above codes.
06	<i>Crime Victim:</i> Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
25	<i>Date Benefits Terminated by Primary Provider:</i> Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
42	<i>Date of Discharge:</i> For final bill of hospice care, enter the date the beneficiary terminated the election of hospice care.

See UB-92 Billing Manual for additional codes.

### **Item 36(a-b): Occurrence Span Code and Dates** (not required)

### **Item 37: Internal Control Number (ICN)/Document Control Number (DCN)** (not required)

### **Item 38: Responsible Party Name and Address** (not required)

### **Items 39-41(a-d): Value Codes and Amounts** (Required, if applicable.)

If appropriate, enter a value code and the related dollar amount necessary for processing this claim. The value code structure is intended to provide additional reporting capabilities.

Code	Explanation of Code
22	<i>Surplus:</i> Spenddown required to be entered if patient spenddown occurs. This code should be entered together with the dollar amount.

### **Item 42: Revenue code**

Enter revenue code 001 on the last line, indicating the line on which the sum of all charges on the claim is placed.

### **Item 43: Revenue Description**

Enter the date of service in the MMDDYY format either in this item or in Item 45.

When series billing (i.e. billing from two to four dates of service on the same line), indicate the dates of service in the following format: MMDDYY MMDD MMDD MMDD. Indicate the dates in ascending order.

Providers may enter up to four consecutive dates of service for each revenue or procedure code if:

- All dates of service are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four dates of service per procedure code, indicate the dates on subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim, including the "total charges" line.

Appendix 2  
(cont.)

**Item 44: HCPCS/Rates**

Enter the appropriate five-digit procedure code.

**Item 45: Service Date**

Enter the date of service in the MMDDYY format either in this item or in Item 43 (multiple dates of service are required to be indicated in Item 43).

**Item 46: Units of Service**

Enter the total number of services billed on each line item.

**Item 47: Total Charges** (by revenue code category)

Enter the total charge for each line item. For revenue code 001 (total charges), enter the grand total for all services submitted on the claim.

**Item 48: Noncovered Charges** (not required)

**Item 49: Unlabeled Field** (not required)

**Item 50: Payer Identification**

Indicate Medicaid ("T19-WI Medicaid") and all third-party payers (including Medicare) with possible involvement in this claim. All coverages indicated on the recipient's Medicaid identification card must be addressed.

**Item 51: Provider Number**

Enter the provider's eight-digit provider number on line B.

**Item 52: Release Information Certification Indicator** (not required)

**Item 53: Benefits Assigned** (not required)

**Item 54: Prior Payments-Payer and Patient** (Required, if applicable.)

If applicable, enter the amount the provider has received toward payment of this bill prior to the billing date by the indicated payer. If "other insurance" denied the claim, enter \$0.00 (do not indicate Medicare payment).

**Item 55: Estimated Amount Due** (not required)

**Item 56: Unlabeled Field** (not required)

**Item 57: Unlabeled Field** (not required)

**Item 58: Insured's Name** (not required)

**Item 59: Patient's Relationship to Insured** (not required)

**Item 60: Certification Number, Social Security Number, Health Insurance Claim Number Identification Number**

On line B, enter the recipient's 10-digit Medicaid ID number as it appears on his or her Forward card.

**Item 61: Insured Group Name** (not required)

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for current policy



**Item 62: Insurance Group Number** (not required)

**Item 63: Treatment Authorization Code**

On line B, enter the seven-digit prior authorization number from the approved Prior Authorization Request Form. Services authorized under separate prior authorization numbers are required to be billed on separate claim forms with their respective prior authorization numbers.

**Item 64: Employment Status Code** (not required)

**Item 65: Employer Name** (not required)

**Item 66: Employer Location** (not required)

**Item 67: Principal Diagnosis Code**

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code is required to be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology (“E”) codes may not be used as a primary diagnosis. Manifestation (“M”) codes are not valid diagnosis codes for Wisconsin Medicaid.

**Items 68-75: Other Diagnosis Codes**

Enter the full ICD-9-CM diagnosis codes corresponding to additional conditions related to treatment billed on the claim. Other diagnosis codes will permit the use of ICD-9-CM “E” codes. Manifestation (“M”) codes are not valid diagnosis codes for Wisconsin Medicaid.

**Item 76: Admitting Diagnosis** (not required)

**Item 77: External Cause of Injury (E-Code)** (not required)

**Item 78: Race/Ethnicity** (not required)

**Item 79: Procedure Coding Method Used** (not required)

**Item 80: Principal Procedure Code and Date** (not required)

**Item 81: Other Procedure Codes and Dates** (not required)

**Item 82(a-b): Attending Physician ID** (not required)

**Item 83(a-b): Other Physician ID** (not required)

**Item 84: Remarks** (Enter information when applicable.)

**Private Insurance**

Third-party insurance (private 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 private insurance, leave Item 84 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, *and* the service requires third party billing according to the All-Provider Handbook, and *Medicaid Update*, dated December 1998 (No. 98-38), then one of

## Appendix 2 (cont.)

the following three other insurance (OI) explanation codes *is required to* be indicated in the *first* box of Item 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by health insurance. In Item 54 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do <i>not</i> use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"><li>• Recipient denied coverage or will not cooperate.</li><li>• The provider knows the service in question is not covered by the carrier.</li><li>• Health insurance failed to respond to initial and follow-up claims.</li><li>• Benefits not assignable or cannot get assignment.</li></ul>

When the recipient is a member of an HMO, one of the following must be indicated, *if applicable*:

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

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

### Medicare

Medicare codes cannot be used if one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The *non-physician* provider's Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes can be used when appropriate.

## Appendix 2 (cont.)

### Code Description

M-1 Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

*For Medicare Part A* (all three criteria are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in 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 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 are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in 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.

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 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 are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

## Appendix 2 (cont.)

**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 are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

**M-8** Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

*For Medicare Part A* (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

*For Medicare Part B* (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

### **Item 85 - Provider Representative Signature**

The provider or the authorized representative is required to sign in Item 85. This may be a computer printed name or a signature stamp.

### **Item 86 - Date Bill Submitted**

Enter the date on which the claim is submitted to Wisconsin Medicaid in the MMDDYY format.

# Appendix 3

## UB-92 Claim Form Example - Personal Care Services Series Billing

<b>IM BILLING PROVIDER</b> <b>1 W. WILLIAMS</b> <b>ANYTOWN, WI 55555</b> <b>(555) 222-5555</b>				2				3 PATIENT CONTROL NO. <b>55555ABCD</b>				4 TYPE OF BILL <b>33X</b>																																											
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM				7 COV D		8 N-C D		9 C-I D		10 L-R D		11																																							
12 PATIENT NAME <b>RECIPIENT IMA</b>								13 PATIENT ADDRESS																																															
14 BIRTHDATE <b>032859</b>				15 SEX M		16 MS		17 DATE		18 HR		19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO. <b>1159899RZ</b>		24		25		26		27		28		29		30		31																			
32 OCCURRENCE DATE				33				34 OCCURRENCE DATE				35				36 OCCURRENCE SPAN FROM THROUGH				37				38																															
39 CODE				40 VALUE CODES AMOUNT				41 CODE				42 VALUE CODES AMOUNT				43				44																																			
45 REV. CD.				46 DESCRIPTION				47 HCPCS / RATES				48 SERV. DATE				49 SERV. UNITS				50 TOTAL CHARGES				51 NON-COVERED CHARGES				52																											
001				071099, 0713, 0725, 0731 071099, 0713, 0715, 0717 073199 <b>TOTAL</b>				W9900 W9902 W9044								4.0 2.0 1.0				5000 30 00 45 00 <b>185 00</b>																																			
53 PAYER <b>XXX-Medicare</b> <b>T19-WI Medicaid</b>								54 PROVIDER NO. <b>88000800</b>								55 REL INFO				56 ASG BEN				57 PRIOR PAYMENTS				58 EST AMOUNT DUE				59																							
60 INSURED'S NAME								61 P REL								62 CERT. - SSN - HIC - ID NO. <b>1234567890</b>								63 GROUP NAME				64 INSURANCE GROUP NO.																											
65 TREATMENT AUTHORIZATION CODES								66 ESC								67 EMPLOYER NAME								68 EMPLOYER LOCATION																															
69								70								71								72																															
73 PRIN DIAG CD <b>5750</b>								74 CODE								75 OTHER DIAG. CODES								76 CODE								77 ADM DIAG CD								78 E-CODE								79							
80 PRINCIPAL PROCEDURE CODE <b>5750</b>								81 OTHER PROCEDURE CODE <b>5750</b>								82 OTHER PROCEDURE CODE <b>5750</b>								83 OTHER PROCEDURE CODE <b>5750</b>								84 ATTENDING PHYS. ID <b>88888888</b>								85 OTHER PHYS. ID															
86 REMARKS <b>M-</b> <b>OL-</b>								87								88								89								90																							
91								92								93								94								95																							
96								97								98								99								100																							

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## Appendix 4

### Billing Reference Guidelines

#### Rounding Guidelines for Personal Care Services and Travel Time

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s):

<u>Time (in minutes)</u>	<u>Unit(s) Billed</u>
1-30	0.5
31-44	0.5
45-60	1.0
61-74	1.0
75-90	1.5
91-104	1.5
105-120	2.0
121-134	2.0
etc.	etc.

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#### Allowable Personal Care Procedure Codes

<b>Procedure Code</b>	<b>Description</b>
	<u>Bill units in time increments</u>
W9900	Personal Care by Personal Care-Only Agency
W9903	Personal Care by Dually Certified Home Health/Personal Care Agency
W9902	Personal Care Travel Time
	<u>Bill units in visit increments</u>
W9906	Registered Nurse Supervisory Visit (recipient receives only unskilled services) Wisconsin Medicaid reimbursement limited to once every 50-60 days
W9044	Personal Care Supervisory Visit (recipient also receives skilled services) Wisconsin Medicaid reimbursement limited to once a month if medically necessary



Appendix 4  
(cont.)

Allowable Place of Service (POS) Codes  
Personal Care Services

POS Code	Description
4	Home (personal care services, RN supervisory visits, and travel time are provided in the home)
0	Other

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Allowable Type of Service (TOS) Codes  
Personal Care Worker

TOS Code	Description
1	Medical
9	Other (use only when billing for disposable medical supplies)

## Appendix 5

### HCFA 1500 Claim Form Instructions For Disposable Medical Supplies (DMS)

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. No other elements are required.

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

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

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

#### **Element 1a - Insured's I.D. Number**

Enter the recipient's 10-digit Medicaid identification 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. Write the name exactly as it appears on the Wisconsin Medicaid identification card.

#### **Element 3 - Patient's Birth Date, 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/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

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

#### **Element 5 - Patient's Address**

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

#### **Element 6 - Patient Relationship to Injured** (not required)

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

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

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

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

- When the recipient has dental (DEN) insurance only or has no private insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, *and* the service requires third party billing according to the All-Provider Handbook, and *Medicaid Update*, dated December, 1998 (No. 98-38), then one of the following three other insurance (OI) explanation codes *is required to* 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.)

## Appendix 5 (cont.)

Code	Description
<b>OI-P</b>	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.
<b>OI-D</b>	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do <i>not</i> use this code unless the claim in question was actually billed to and denied by the health insurer.
<b>OI-Y</b>	YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> <li>• Recipient denied coverage or will not cooperate.</li> <li>• The provider knows the service in question is not covered by the carrier.</li> <li>• Health insurance failed to respond to initial and follow-up claims.</li> <li>• Benefits not assignable or cannot get assignment.</li> </ul>

When the recipient is a member of an HMO, one of the following must be indicated, *if applicable*:

Code	Description
<b>OI-P</b>	PAID by HMO. The amount paid is indicated on the claim.
<b>OI-H</b>	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

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

### Element 10 - Is Patient's Condition Related to: (not required)

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

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The *non-physician* provider's Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes can be used when appropriate:

## Appendix 5 (cont.)

### Code Description

M-1 Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

*For Medicare Part A* (all three criteria are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in 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 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 are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in 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.

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 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 are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

## Appendix 5 (cont.)

**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 are required to be met):

- The provider is identified in 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 are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

**M-8** Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

*For Medicare Part A* (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

*For Medicare Part B* (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

**Element 12 - Patient's or Authorized Person's Signature** (not required)

**Element 13 - Insured's or Authorized Person's Signature** (not required)

**Element 14 - Date of Current Illness, etc.** (not required)

**Element 15 - If Patient Has Had Similar Illness, Give First Date** (not required)

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

**Element 17 - Name of Referring Physician or Other Source**

Enter the referring or prescribing physician's name.

**Element 17a - I.D. Number of Referring Physician**

Enter the referring/prescribing physician's six-character UPIN number. If the UPIN number is not available, enter the eight-digit Medicaid provider number or license number of the referring physician.

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

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

**Element 20 - Outside Lab?**

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab.

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

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

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.  
P. O. Box 96561  
Washington, D.C. 20090  
(800) 632-0123

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

**Element 23 - Prior Authorization Number**

Enter the seven-digit prior authorization (PA) number from the approved PA request form. Services authorized under multiple PAs are required to be billed on a separate claim form with their respective PA numbers. Disposable medical supplies (DMS) requested over the monthly limitations must be prior authorized.

**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/CCYY 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/CCYY 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.

## Appendix 5 (cont.)

- 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.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

### **Element 24B - Place of Service**

Enter the appropriate Wisconsin Medicaid single-digit place of service (POS) code for each service. Refer to Appendix 3 of this section for a list of all allowable place of service codes and their descriptions.

### **Element 24C - Type of Service**

Enter the appropriate Wisconsin Medicaid single-digit type of service (TOS) code for each service. Refer to Appendix 3 of this section for a list of all allowable type of service codes and their descriptions.

### **Element 24D - Procedures, Services, or Supplies**

Enter the single most appropriate five-character HCFA Common Procedure Coding System (HCPCS) code, or local procedure code. Claims received without the appropriate HCPCS or local code are denied by Medicaid.

Only the HCPCS procedure codes in the most recent DMS Index (which is updated and sent out to providers periodically) are covered by Medicaid.

### **Modifiers**

Enter the appropriate Medicaid modifier in the "Modifier" column of Element 24D. Medicaid-allowable modifiers can be found in the DMS Index.

### **Element 24E - Diagnosis Code**

When multiple procedures related to different diagnoses are listed, enter the diagnosis code that corresponds with the procedure code in Element 24D. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

### **Element 24F - Charges**

Enter the total charge for each line item.

### **Element 24G - Days or Units**

Enter the total number of services billed for each line item.

### **Element 24H - EPSDT/Family Plan**

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if *both* HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.



## Appendix 5 (cont.)

### **Element 24I - EMG**

Enter an “E” for *each* procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this Element blank.

### **Element 25 - Federal Tax I.D. Number** (not required)

### **Element 26 - Patient’s Account Number**

Optional - provider may enter up to 12 characters of the patient’s internal office account number. This number will appear on the Remittance and Status (R/S) Report.

### **Element 27 - Accept Assignment** (not required)

### **Element 28 - Total Charge**

Enter the total charges for this claim.

### **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 this element, “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/CCYY format.

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

### **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 billing provider. At the bottom of Element 33, enter the billing provider’s eight-digit Medicaid provider number.

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## HCFA 1500 Claim Example - Disposable Medical Supplies (DMS)

APPROVED OMB-0938-0008

PICA				HEALTH INSURANCE CLAIM FORM				PICA			
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER				1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)							
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)				5555555555							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
Recipient, Im A.				MM DD YY 03 28 59 M F X							
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)			
123 Robin Rd.				Self Spouse Child Other							
CITY				8. PATIENT STATUS				CITY			
Anytown				Single Married Other				STATE			
STATE WI				Employed Full-Time Student Part-Time Student				ZIP CODE			
ZIP CODE				TELEPHONE (Include Area Code)				TELEPHONE (INCLUDE AREA CODE)			
55555				(XXX) XXX-XXXX				( )			
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			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH			
				YES NO				MM DD YY M F			
b. OTHER INSURED'S DATE OF BIRTH				b. AUTO ACCIDENT? PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME			
MM DD YY M F				YES NO							
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME			
				YES NO							
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.			
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.								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								SIGNED			
DATE								DATE			
14. DATE OF CURRENT: 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			
ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)								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			
I.M. Referring				123456				FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE								20. OUTSIDE LAB? \$ CHARGES			
								YES NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)								22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
1. 5750				3. . . .				23. PRIOR AUTHORIZATION NUMBER			
2. . . .				4. . . .							
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE											
MM DD YY MM DD YY				CPT/HCPCS MODIFIER							
07 03 99				4 9 A6201				1 45 00 20			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)			
								YES NO			
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.)				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 #			
Ima Biller				8-1-99				I.M. Billing PCW 1 W. Williams Anytown, WI 55555			
SIGNED				DATE				PIN# GRP# 88000800			

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

PLEASE PRINT OR TYPE

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

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## Appendix 7

### Avoiding Common Denials

Some common denial codes from claims, and the appropriate solutions for these denials, are shown in the box below.

<b>Explanation of Benefit Code (Denial Code)</b>	<b>Correction</b>
100- Claim previously/partially paid on 24XXXXXXXXXXXX on Remittance Advice date 02XXXX. Adjust paid claim.	Review paid claim and adjust appropriately.
399- Date of service must fall between the prior authorization grant and expiration date.	Review date of service on claim. Does it fall between the grant and expiration date on the prior authorization (PA)? If dates of service are from two PAs, you must split bill each with the correct PA number (only one PA number is allowed per claim).
970- Personal care in excess of 50 hours per calendar year requires PA.	PA is required for hours billed and paid in excess of 50 per calendar year.
322- Service(s) denied/cutback – the maximum PA service limitation frequency allowance has been exceeded.	The numbers of hours for the PA listed on the claim have been used up. If you have received an approved PA for more hours, bill with the correct PA number.
010- Recipient is eligible for Medicare.	Use the appropriate Medicare disclaimer code or attach Medicare EOB if Medicare paid.
388- Incorrect or Invalid type of service, National Drug Code or procedure code.	Enter the correct procedure code in Item 44.
652- Denied supervisory visit for unskilled cases allowed once per 60 days.	Supervisory visit only allowed once per 60 days using procedure code W9906.
398- PA number submitted is missing or incorrect.	Enter the correct seven-digit PA number in Item 63.
281- Recipient Wisconsin Medicaid identification number is incorrect.	Enter the correct 10-digit Medicaid ID number in Item 60 of the UB-92 Claim Form. Verify correct Medicaid ID number with one of the eligibility resources available.
614- Recipient's first name does not match number.	Enter recipient's name, as it appears on your eligibility file, in Item 12 of the UB-92 Claim Form. Verify name with one of eligibility resources available.
172- Recipient not eligible for date of service.	Verify recipient's eligibility with one of the eligibility resources available.
171- Claim/adjustment received after 12 months from the date of service.	See the All-Provider Handbook for late billing exceptions.

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# Glossary of Common Terms

**Activities of daily living (ADL)**

Activities of daily living are activities relating to the performance of self care, including dressing, feeding or eating, grooming, and mobility.

**Coverage determination software (CDS)**

Coverage determination software is computer software that providers are required to use for recipients who are eligible for both Wisconsin Medicaid and Medicare. The software helps providers identify when they should bill Medicare before billing Wisconsin Medicaid.

**Community Services Deficit Reduction Benefit (CSDRB)**

Community Services Deficit Reduction Benefit is a Wisconsin Medicaid program that makes federal financial participation funds available to counties, local health departments and tribal agencies to reimburse these agencies for funds they expend in excess of Wisconsin Medicaid reimbursement for personal care and selected other non-institutional services.

**Date of service**

The date of service is the calendar date on which a specific medical service is performed.

**Disposable medical supplies (DMS)**

Disposable medical supplies are medically necessary items which have a very limited life expectancy and are consumable, expendable, disposable, or nondurable.

**Dual entitlee**

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

**Dually certified agency**

A dually certified agency is an agency that is Medicaid-certified to provide both home health and personal care services.

**HCFA 1500**

The HCFA 1500 is the Health Care Financing Administration claim form used for billing DMS.

**Medicare**

Medicare is a national health insurance program for people 65 years of age and older, certain younger people with disabilities, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

**Personal care worker (PCW)**

A personal care worker is an individual employed by a personal care provider certified under HFS 105.17, Wis. Admin. Code, or under contract to the personal care provider to provide personal care services under the supervision of a registered nurse.

**Provider**

A personal care provider is a home health agency, county department, independent living center, tribe, or public health agency that has been certified by Wisconsin Medicaid to provide personal care services to recipients and to be reimbursed by Wisconsin Medicaid for those services.

**Place of service (POS)**

The place of service is the place where the service was performed. For Wisconsin Medicaid prior authorization and billing purposes, it is identified by a single-digit code.

**Qualified Medicare Beneficiary Only (QMB-Only)**

QMB-Only recipients are only eligible for Medicaid coverage of the coinsurance and the deductibles for Medicare-allowed claims.

**Registered nurse (RN)**

A registered nurse is a person who holds a current Wisconsin license as a registered nurse under ch. 441, Wis. Stats., or, if practicing in another state, is registered with the appropriate licensing agency in that state.

**Supervision**

Supervision of personal care services is required to be performed by a qualified RN who reviews the Plan of Care (POC), evaluates the recipient's condition, and observes the personal care worker (PCW) performing assigned tasks at least every 60 days. Supervision requires intermittent face-to-face contact between supervisor and assistant and regular review of the assistant's work by the supervisor according to HFS 101.03(173), Wis. Admin. Code. Supervisory review includes:

- A visit to the recipient's home.
- Review of the PCWs daily written record.
- Discussions with the physician of any necessary changes in the POC, according to HFS 107.112(3)(c), Wis. Admin. Code.

**Travel time**

Travel time is the time spent traveling to and from the recipient's residence and the previous or following personal

care appointment, the personal care worker's residence, or the provider's office.

**Type of service (TOS)**

The type of service identifies the general category of medical services. For Wisconsin Medicaid prior authorization and billing purposes, it is identified by a single-digit code.

**UB-92**

The UB-92 is the claim form used for personal care services.

**Usual and customary charge**

The provider's charge for providing the same service to persons not entitled to Medicaid benefits is the usual and customary charge.

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