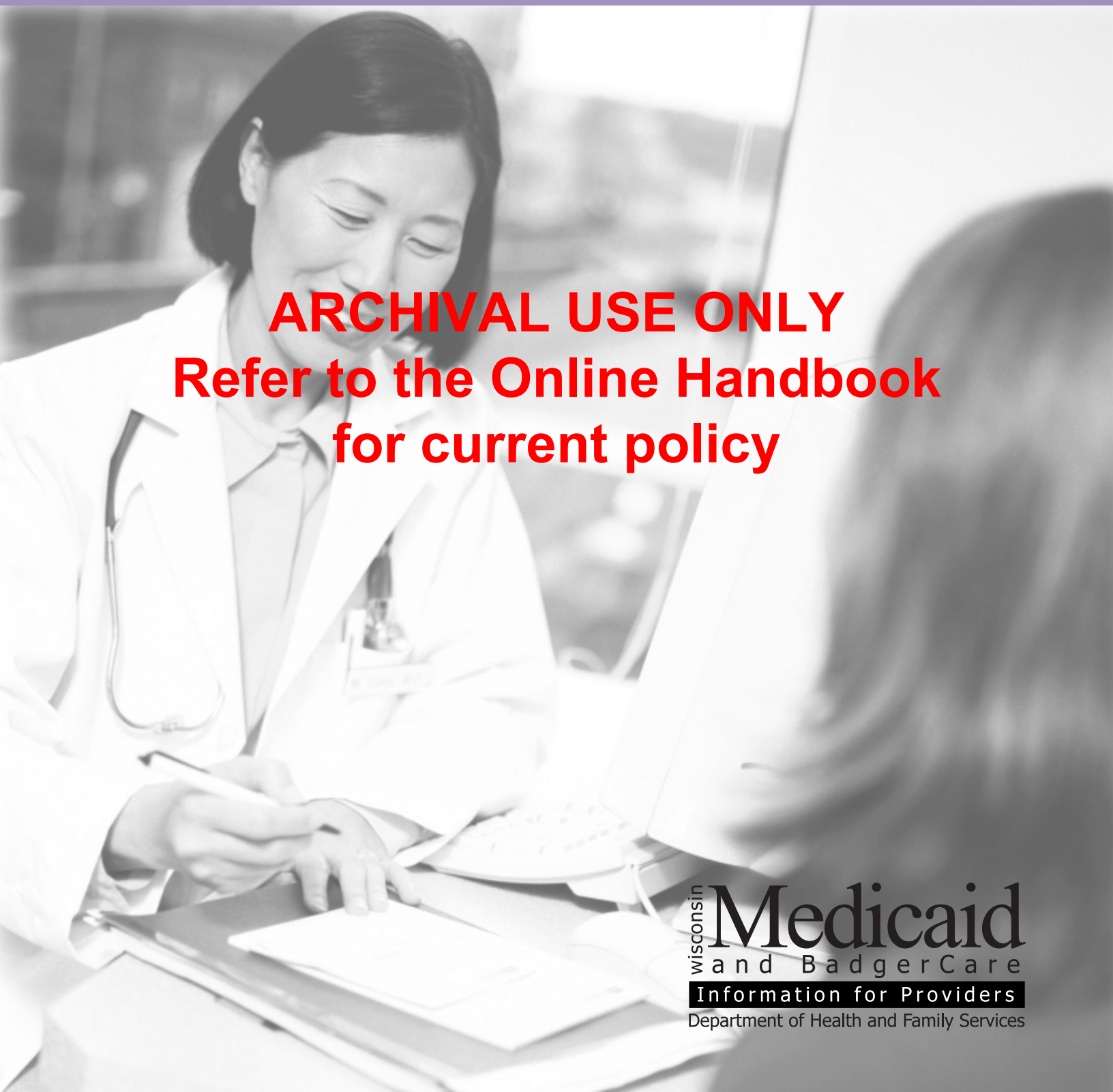
# Family Planning Clinic Services



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

# Important Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility:

| Service | Information Available | Telephone Number | Hours |
|---|---|---|---|
| **Automated Voice Response (AVR) System** (Computerized voice response to provider inquiries.) | Checkwrite Information<br>Claim Status<br>Prior Authorization Status<br>Recipient Eligibility* | (800) 947-3544<br>(608) 221-4247 (Madison area) | 24 hours a day/ 7 days a week |
| **Personal Computer Software and Magnetic Stripe Card Readers** | Recipient Eligibility* | Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors. | 24 hours a day/ 7 days a week |
| **Provider Services** (Correspondents assist with questions.) | Checkwrite Information<br>Claim Status<br>Prior Authorization Status<br>Provider Certification<br>Recipient Eligibility* | (800) 947-9627<br>(608) 221-9883 | Policy/Billing and Eligibility:<br>8:30 a.m. - 4:30 p.m. (M, W-F)<br>9:30 a.m. - 4:30 p.m. (T)<br>Pharmacy:<br>8:30 a.m. - 6:00 p.m. (M, W-F)<br>9:30 a.m. - 6:00 p.m. (T) |
| **Direct Information Access Line with Updates for Providers (Dial-Up)** (Software communications package and modem.) | Checkwrite Information<br>Claim Status<br>Prior Authorization Status<br>Recipient Eligibility* | Call (608) 221-4746 for more information. | 7:00 a.m. - 6:00 p.m. (M-F) |
| **Recipient Services** (Recipients or persons calling on behalf of recipients only.) | Recipient Eligibility<br>Medicaid-Certified Providers<br>General Medicaid Information | (800) 362-3002<br>(608) 221-5720 | 7:00 a.m. - 5:00 p.m. (M-F) |



*Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation.

Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Scott McCallum
Governor

Phyllis J. Dubé
Secretary

**State of Wisconsin**

Department of Health and Family Services

**DIVISION OF HEALTH CARE FINANCING**

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**M E M O R A N D U M**

**DATE:** November 15, 2002

**TO:** Family Planning Clinics, Managed Care Organizations

**FROM:** Peggy B. Handrich, Administrator
Division of Health Care Financing

**SUBJECT:** New Family Planning Clinic Services Handbook

The Division of Health Care Financing (DHCF) is pleased to provide you with a copy of the new Family Planning Clinic Services Handbook.

All policies included in the handbook are effective for dates of services on and after February 1, 2003. Please utilize your current handbook, Part E, the Family Planning Clinics Handbook, until that date.

The Family Planning Clinic Services Handbook incorporates current Medicaid family planning policy information into a single reference source. The handbook replaces all prior family planning clinic publications including Part E, the Family Planning Clinics Handbook, dated September 1981, except for the following *Wisconsin Medicaid and BadgerCare Updates*:



- 96-03 New tuberculosis benefit.
- 98-29 SMV Transportation Physician Certification form revised.

This handbook does *not* replace the All-Provider Handbook and all-provider *Wisconsin Medicaid and BadgerCare Updates*, the Wisconsin Administrative Code, or Wisconsin Statutes. Subsequent changes to family planning policies will be published first in *Wisconsin Medicaid and BadgerCare Updates* and later in the Family Planning Clinic Services Handbook revisions.

**Medicaid Family Planning Waiver Program**

The Medicaid Family Planning Waiver Program (FPWP) is a Wisconsin Medicaid expansion program recently approved, which will provide contraceptive services and supplies to low-income women not enrolled in Medicaid or BadgerCare. Wisconsin Medicaid will provide family planning services under this Section 1115(a) Medicaid waiver, for five years beginning January 1, 2003. The FPWP will provide family planning benefits for this new population of women ages 15 through 44 who are at or below 185% of the federal poverty level.

The program will allow low-income women to gain access to family planning and primary care services immediately through Presumptive Eligibility (PE). With FPWP PE, women may receive services the same day they come into a family planning clinic or Federally Qualified Health Center. Women are covered under PE for up to three months, and in the meantime they may apply for continuous FPWP coverage.

This handbook does **not** provide information on the Medicaid Family Planning Waiver Program coverage and policies. Selected family planning services and supplies are covered under the new benefit. A full list will be included in the upcoming Medicaid Provider Update. Wisconsin Medicaid fee-for-service will reimburse providers for these services and supplies.

Examples of covered services include:

- Contraceptive services and supplies.
- Pap tests.
- Colposcopies.
- Sexually transmitted disease tests and other lab tests.
- Routine preventive primary care services.

The FPWP benefit is less inclusive than the full Medicaid family planning benefit. There are some limitations: for example, abortions and hysterectomies are not covered under any circumstances.

**Additional Copies of Publications**

All *Wisconsin Medicaid and BadgerCare Updates* and the Family Planning Clinic Services Handbook can be downloaded from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

We would like to thank everyone who reviewed the handbook and provided comments.

# Table of Contents

# Preface

The Wisconsin Medicaid and BadgerCare Family Planning Clinic Services Handbook is issued to family planning clinics that are Wisconsin Medicaid certified. It contains information that applies to fee-for-service Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or 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 state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.



## Verifying Eligibility

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

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

## Handbook Organization

The Family Planning Clinic Services Handbook consists of the following chapters:

- General Information.
- Covered Services.
- Noncovered Services.
- Preparing Claims.

In addition to the Family Planning Clinic Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

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

## Legal Framework of Wisconsin Medicaid and BadgerCare

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

### Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

### Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

*www.dhfs.state.wi.us/medicaid/*
*www.dhfs.state.wi.us/badgercare/*.

## Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

# General Information

## Provider Information

### Scope of Services

The policies in this handbook apply to family planning clinics only. For general medical services, clinics must obtain the appropriate Medicaid certification(s). Clinics must meet all prior authorization (PA) and other Wisconsin Medicaid requirements applicable to any covered services provided. Refer to the Covered Services chapter in this handbook for further information.

To become a Wisconsin Medicaid-certified family planning clinic, the clinic must meet all eligibility requirements in HFS 105.36, Wis. Admin. Code.

### Provider Eligibility and Certification

To become a Wisconsin Medicaid-certified family planning clinic, the clinic must meet all eligibility requirements in HFS 105.36, Wis. Admin. Code. This includes a survey by the Division of Public Health, Department of Health and Family Services. Each clinic is surveyed upon initial application for certification and is subject to an annual survey thereafter.



#### *Individual Provider Certification*

Individual performing providers in family planning clinics are not required to be individually Medicaid certified. However, providers must meet all applicable licensure provisions in the State of Wisconsin in order to practice in family planning clinics.

### Clinical Certification for Laboratory Services

Congress implemented the Clinical Laboratory Improvement Amendment (CLIA) to improve the quality and safety of laboratory services. CLIA requires all laboratories and providers (including family planning clinics) performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards.

#### *CLIA Enrollment*

The federal Centers for Medicare and Medicaid Services (CMS), formerly HCFA, sends CLIA enrollment information to Wisconsin Medicaid. The enrollment information includes CLIA identification numbers for all current laboratory sites. Wisconsin Medicaid verifies that laboratories are CLIA-certified before issuing a Medicaid provider billing number.

#### *Further CLIA Information*

For further information about CLIA regulations, the scope of CLIA, CLIA certification requirements, and how to become CLIA certified, refer to the Provider Certification section of the All-Provider Handbook which may be downloaded from Wisconsin Medicaid's Web site at: *www.dhfs.state.wi.us/medicaid/*.

### Principles of Operation

As specified in HFS 105.36(2), Wis. Admin. Code, Wisconsin Medicaid requires family planning clinic services to be made available:

- Upon referral from any source or upon the recipient's own request.
- Without regard to race, nationality, religion, family size, marital status, maternity, paternity, handicap or age, in conformity with the spirit and intent of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, as amended.
- With respect for the dignity of the individual.
- With efficient administrative procedures for registration and delivery of services, avoiding prolonged waiting and multiple visits for registration. Recipients should be seen on an appointment basis whenever possible.

### *Acceptance of Services*

Recipient acceptance of family planning clinic services must be voluntary, and individuals may not be subjected to coercion either to receive services or to employ or not to employ a particular method of family planning. Acceptance or nonacceptance of family planning clinic services cannot be a prerequisite to eligibility for, or receipt of, any service funded by local, state, or federal tax revenue.

### *Methods Available*

A variety of medically approved methods of family planning, including the natural family planning method, should be available to recipients.

### *Confidentiality*

All personal information obtained must be treated as privileged communication, held confidential, and divulged only upon the recipient's written consent, except when necessary to provide services to the recipient or to seek reimbursement for services. Family planning clinic directors must ensure that all participating providers preserve the confidentiality of recipient records. Information may be disclosed in summary, statistical, or other forms that do not identify specific recipients.



## Administration

Wisconsin Medicaid requires a governing body to be responsible for the conduct of the staff and the operation of the clinic, according to HFS 105.35(3), Wis. Admin. Code. Clinics must appoint a designated person to be responsible for the day-to-day operation of the clinic.

### *Policies and Procedures*

Written policies and procedures must be developed governing utilization of staff, services to recipients, and the general operation of the clinic. Clinics must also prepare job descriptions for volunteer and paid staff to assist staff members in the performance of their duties.

### *Record Keeping*

Clinics are required to develop a record system that includes recipient, fiscal, and organizational records, as follows:

- *Recipient records.* Clinics must retain recipient records which include pertinent medical and social history and all recipient contacts and outcomes. Records for the purpose of following up on recipients for medical services or referrals to other community resources and for the purpose of program evaluation must be retained. Accumulated data on supplies, staffing, appointments, and other administrative functions must be kept.
- *Fiscal records.* Clinics must retain fiscal records accounting for cash flow.
- *Organizational records.* Organizational records must be retained to document governing body meetings, staff time, administrative decisions, and fund raising.
- *Other record requirements.* Clinics must evaluate, report, plan, and implement changes in program operation and develop a system of appointments and referrals flexible enough to meet community needs. Clinics must also make provisions for an after-hours medical backup for recipients experiencing family planning-related problems when the clinic staff is not available.

## Staffing

As described in HFS 105.36(4), Wis. Admin. Code, family planning clinic staff, either paid or volunteer, perform the following functions:

- *Outreach workers* or *community health personnel* have a primary responsibility to contact individuals in need of family planning clinic services, initiate family planning counseling, and assist in receiving,

All personal information obtained must be treated as privileged communication, held confidential, and divulged only upon the recipient's written consent, except when necessary to provide services to the recipient or to seek reimbursement for services.

successfully using, and continuing family planning medical services.

- The *secretary* or *receptionist* greets recipients at the clinic, arranges for services, and performs a variety of necessary clerical duties.
- The *interviewer* or *counselor* takes social histories, provides family planning information to recipients, and counsels them regarding their family planning-related problems.
- The *nurse* or *clinic aide* assists the physician in providing medical services to the recipient.
- The *physician* supervises all medical and related services provided to recipients.
- The *clinic coordinator* oversees the clinic's operation.

*Note:* Nurse practitioners and physician assistants may also perform or supervise services provided to recipients.



### *Training and Development*

Clinics must:

- Develop training programs for new staff.
- Allow time for staff conferences and in-service training in new techniques and procedures for existing staff.
- Allow time for staff to coordinate, train, and supervise volunteers to be an effective, integral part of the clinic.

Paraprofessional personnel may also be hired and trained.

## Recipient and Community Outreach

According to HFS 105.36(5), Wis. Admin. Code, Wisconsin Medicaid requires family planning clinics to develop an active outreach effort aimed at:

- Recruiting and retaining recipients.
- Meeting needs by making referrals (where appropriate).
- Increasing community awareness about the clinic.

### *Recruiting and Retaining Recipients*

Outreach efforts should include recruiting and retaining recipients in the family planning clinic through:

- A system of identifying primary target populations.
- A method of contacting the target population.
- Procedures for family planning counseling and motivating appropriate persons to avail themselves of family planning medical services.
- Assisting individuals in receiving family planning medical services.
- Activities designed to follow-up potential and actual family planning recipients, as indicated.
- A sufficient record system.

### *Referrals*

Outreach efforts should aim to meet all needs through appropriate and effective referrals to other community resources.

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### *Community Awareness*

Outreach efforts should aim to increase community awareness and acceptance of the family planning clinic through:

- Use of mass media.
- Presentations to community organizations and agencies.
- Public information campaigns utilizing all channels of communication.
- Development of formal referral arrangements with community resources.
- Involvement of appropriate community residents in the operation of the family planning clinic.

## Facilities

According to HFS 105.36(8), Wis. Admin. Code, the design of family planning clinics should provide comfort and dignity for recipients and facilitate the work of clinic staff.

Clinic facilities must be adequate for the quantity of services provided and should include:

- A comfortable waiting room with an area for patient reception, record processing, and children's play.
- Private interviewing and counseling areas.
- A group conference room for staff meetings and recipient education.
- A work room or laboratory area with sufficient equipment and nearby storage space, none of which is accessible to recipients.
- A sufficient number of private and well-equipped examining rooms with proximal dressing areas, ensuring the dignity of the recipient.
- Adequate toilet facilities, preferably near the dressing room.
- Arrangements for routine and restorative facility maintenance.

# Recipient Information

## Recipient Eligibility

Wisconsin Medicaid providers should *always* verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System provides eligibility information that providers can access a number of ways. Medicaid HMOs may not require referrals or PA for out-of-network family planning services.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility. You may also refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility.

## Medicaid Managed Care Coverage

Wisconsin Medicaid fee-for-service reimburses Medicaid-certified family planning clinics when a state-contracted HMO enrollee chooses to seek these services from a Medicaid-certified provider outside the HMO network. However, Wisconsin Medicaid encourages Medicaid HMO enrollees to seek family planning services from within their HMO's provider network.

Claims for services provided to Medicaid HMO enrollees by family planning clinics are submitted to Wisconsin Medicaid as fee-for-service claims. Wisconsin Medicaid reimburses for the services according to the applicable Terms of Reimbursement if the enrollee is eligible on the date of service and all other program requirements are met.

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



## Coordination of Benefits

### *Health Insurance Coverage*

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

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

- Birth to 3.
- The Crime Victim Compensation Fund.
- General Assistance.
- Title V of the Social Security Act, Maternal and Child Health Services, relating to the Program for Children with Special Health Care Needs.
- The Wisconsin Adult Cystic Fibrosis Program.

Wisconsin Medicaid fee-for-service reimburses Medicaid-certified family planning clinics when a state-contracted HMO enrollee chooses to seek these services from a Medicaid-certified provider outside the HMO network.

- The Wisconsin Chronic Renal Disease Program.
- The Wisconsin Hemophilia Home Care Program.

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

*Medicare Coverage*

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

Refer to the Coordination of Benefits section of the All-Provider Handbook for information about Medicare-allowed claims (called crossover claims).

### Copayment

Providers are not permitted to charge copayments for family planning services.

### Confidentiality

To assure privacy for the Medicaid recipient, Wisconsin Medicaid does not identify any family planning services on the recipient Explanation of Benefits, which is sent to a random group of recipients on a monthly basis.

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# Covered Services



## Covered Family Planning Clinic Services

Covered services for family planning clinics include family planning-related:

- Evaluation and management (E&M) services.
- Surgery services.
- Laboratory and radiology services.
- Supplies.

All family planning clinic services performed in family planning clinics must be directed by a physician or a nurse practitioner and provided or supervised by a physician, nurse practitioner, or registered nurse. Refer to Appendix 1 of this handbook for a list of procedure codes for covered family planning clinic services.

All family planning clinic services performed in family planning clinics must be directed by a physician or a nurse practitioner and provided or supervised by a physician, nurse practitioner, or registered nurse.



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

Refer to HFS 107.03 and 107.06(5), Wis. Admin. Code, and to the Noncovered Services chapter of this handbook for information about services not covered by Wisconsin Medicaid.

## Evaluation and Management Services

Wisconsin Medicaid reimburses for the following E&M services, defined further within this chapter:

- Initial and annual physical examinations.
- Follow-up office visits.
- Preventive medicine services.
- Prescriptions.
- Counseling services.

Providers should submit claims for the single lowest, most appropriate E&M code, based on standard coding methodologies.

### Initial and Annual Physical Examinations

According to HFS 107.21(1)(b), Wis. Admin. Code, initial and annual physical examinations with health history (procedure codes 99201-99205 and W6211 [new patient] and 99211-99215 and W6212 [established patient]) are covered family planning clinic services. These services may include the following:

- Complete obstetrical history, including menarche, menstrual, gravidity, parity, pregnancy outcome and complication of pregnancy/delivery, and abortion history.
- Family, social, physical health, and mental health history. For example, chronic illnesses, genetic aberrations, and mental depression.
- History of previous contraceptive use.
- History of significant illness-morbidity, hospitalization and previous medical care (particularly about thromboembolic disease), breast and genital neoplasm, diabetic and prediabetic condition, cephalgia and migraine, pelvic inflammatory disease, gynecologic and venereal disease.
- Physical examination. Recommended procedures for examination should include, but are not limited to:
  - √ Abdominal examination.
  - √ Auscultation of heart and lungs.
  - √ Blood pressure.
  - √ Examination of breasts and axillary glands.
  - √ Extremities.
  - √ Height and weight.
  - √ Pelvic examination .
  - √ Thyroid palpation.

### Follow-Up Office Visits

Follow-up office visits performed by either a nurse or physician are covered services that

may include, but are not limited to, the following:

- Follow-up diagnostic procedures due to positive results from previous procedures.
- Dissemination of contraceptive supplies and assessments of contraceptive methods. For contraceptive pills, Wisconsin Medicaid covers a follow-up office visit once during the first 90 days after the initial prescription to assess physiological changes. This visit must include blood pressure and weight, interim history, and laboratory examination(s) as necessary.
- Office visits for the purpose of diagnosing pregnancies.
- Consultation with registered nurses with no organized instruction or medical testing.

## Preventive Medicine Services

Wisconsin Medicaid reimburses family planning clinic providers for preventive medicine services provided to eligible recipients.



Covered services include initial preventive medicine E&M of new patients (Physician's *Current Procedural Terminology* [CPT] 99384-99387) and reevaluation and management of established patients (CPT 99394-99397), including:

- A comprehensive history.
- A comprehensive examination.
- Counseling/anticipatory guidance/risk factor reduction interventions.
- The ordering of appropriate laboratory/ diagnostic procedures.

## Prescriptions

### *Prescribing Contraceptive Methods*

The prescribing of contraceptive methods is a covered service with reimbursement included in the reimbursement for the office visit. The contraceptive method selected should be the choice of the recipient, based on full information, except when in conflict with sound medical practice.

The following Medicaid-covered services may be prescribed:

- Natural family planning.
- Contraceptive implants.
- Diaphragms.
- Intrauterine devices (IUDs).
- Contraceptive pills.
- Emergency contraception.

### *Prescribing Breast Pumps*

Wisconsin Medicaid reimburses for the prescribing of breast pumps as part of an E&M office visit. Wisconsin Medicaid covers three types of breast pumps:

- Manual or pedal-powered with single- or double-pumping kit.
- Electric, hospital grade, including single- or double-pumping kit.
- Powered/electric, portable with intermittent suction, including single- or double-pumping kit.

Family planning clinic providers may prescribe breast pumps to recipients who meet all of the following criteria:

- The recipient has recently delivered a baby and a physician has ordered or recommended mother's breast milk for the infant.
- Documentation indicates there is the *potential* for adequate milk production.
- Documentation shows there is a long-term need and planned use of the breast pump to obtain a milk supply for the infant.
- The recipient is capable of being trained to use the breast pump, as indicated by the physician or provider.
- Current or expected physical separation of mother and infant (e.g., illness, hospitalization, or work) would make breast-feeding difficult, or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

Wisconsin Medicaid reimburses family planning clinic providers for preventive medicine services provided to eligible recipients.

Family planning clinic physicians or nurse practitioners may prescribe breast pumps for recipients, which can then be obtained through a Medicaid-certified durable medical equipment (DME) provider or pharmacy.

Refer to Appendix 11 for a copy of the optional Breast Pump Order form that the prescribing family planning clinic provider may complete.

Family planning clinic physicians or nurse practitioners may prescribe breast pumps for recipients, which can then be obtained through a Medicaid-certified durable medical equipment (DME) provider or pharmacy. Wisconsin Medicaid does not reimburse family planning clinics for *supplying* breast pumps, unless they are also Medicaid certified as a DME provider or pharmacy.

### Counseling Services

Counseling services in the clinic are covered and may be performed or supervised by a physician, registered nurse, or nurse practitioner, according to HFS 107.21(1)(d), Wis. Admin. Code. Counseling services may be provided as a result of a recipient's request or by indications from exam procedures and history. Wisconsin Medicaid denies reimbursement for counseling services not identified as part of an E&M service (Physicians' CPT counseling codes [99401-99404] are not recognized by Wisconsin Medicaid).



According to HFS 107.21(1)(d), Wis. Admin. Code, covered counseling services are limited to the following areas:

- Instruction on reproductive anatomy and physiology.
- Overview of available methods of contraception, including natural family planning. An explanation of the medical ramifications and effectiveness of each must be provided.
- Sexually transmitted disease information.
- Information about sterility and a full explanation of sterilization procedures, including:
  - √ Associated discomfort.
  - √ Risks.
  - √ Benefits.
  - √ Irreversibility.
- Information about genetics and a full explanation of procedures utilized in genetic assessment, including information regarding the medical ramifications for unborn children and planning of care for unborn children with either diagnosed or possible genetic abnormalities.
- Information regarding teratologic evaluations.
- Information and education regarding pregnancies requested by the recipient, including prenatal counseling and referral.
- Information regarding alcohol abuse, sexual abuse, and domestic violence.

## Surgery Services

### Abortions

#### *Coverage Policy*

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.
2. In a case of sexual assault or incest, provided that prior to the abortion the physician attests, to his or her belief that sexual assault or incest has occurred by signing a certification, and provided that the crime has been reported to the law enforcement authorities.
3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.

Refer to Appendix 4 of this handbook for an optional Abortion Certification Statement form, which may be used for photocopying.

Providers may develop a form of their own, provided it includes the same information.

### *Covered Services*

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services. Wisconsin Medicaid covers treatment for complications arising from an abortion, regardless of whether the abortion itself was a covered service. Because the complications represent new conditions and thus the services are not directly related to the performance of an abortion.

### *Coverage of Mifeprex*

Wisconsin Medicaid reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion procedures under s. 20.927, Wis. Stats. Under federal law, only physicians may obtain and dispense Mifeprex.



When submitting claims for Mifeprex, providers are required to:

- Use the Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System, code S0190 (Mifepristone, oral, 200 mg), TOS "1," for the first dose of Mifeprex, along with the E&M code that reflects the service provided.
- Use the HCPCS code S0191 (Misoprostol, oral, 200 mcg), TOS "1," for the drug given during the second visit, along with the E&M code that reflects the service provided.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* abortion diagnosis code with each claim submission.
- Attach to each claim a completed Abortion Certification Statement that includes information showing the situation is one in which Wisconsin Medicaid covers abortion. Refer to Appendix 4 of this handbook for the Abortion Certification Statement.

*Note:* Wisconsin Medicaid denies claims for Mifeprex reimbursement when billed with a National Drug Code.

### *Physician Counseling Visits Under s. 253.10, Wis. Stats.*

Section 253.10, Wis. Stats., provides that a woman's consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute. That information includes, among other things, all of the following:

- Whether the woman is pregnant.
- Medical risks associated with the woman's pregnancy.
- Details of the abortion method that would be used.
- Medical risks associated with the particular abortion procedure.
- "Any other information that a reasonable patient would consider material and relevant to a decision of whether or not to carry a child to birth or to undergo an abortion."

Wisconsin Medicaid will cover an office visit during which a physician provides the information required under s. 253.10, Wis. Stats., even if the woman decides to undergo an abortion and even if the abortion performed is not Medicaid covered.

Pursuant to s. 253.10, Wis. Stats., the Department of Health and Family Services has issued preprinted material summarizing the statutory requirements under s. 253.10, Wis. Stats. Providers may contact their local health departments for these materials.

### *Services Incidental to a Noncovered Abortion*

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of

Wisconsin Medicaid reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion procedures under s. 20.927, Wis. Stats.

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid.

the following services when directly related to the performance of a noncovered abortion:

- Laboratory testing and interpretation.
- Recovery room services.
- Routine follow-up visits.
- Transportation.
- Ultrasound services.

### *Services Performed by Providers of a Noncovered Abortion*

A Medicaid provider performs a noncovered abortion on a Medicaid recipient. The provider claims reimbursement for other services that were provided to the same recipient between nine months prior to and six weeks after the noncovered abortion. Wisconsin Medicaid requires the provider in this situation to comply with the following requirements:

- All claims must be submitted on paper, not electronically.
- Each claim must have the following signed written statement:

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

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



## Contraceptive Implants

Wisconsin Medicaid covers contraceptive implant devices (e.g., Norplant). Reimbursement for the contraceptive implant procedure includes the E&M service, supplies, and the cost of the device. Providers should not submit claims for E&M services and supplies associated with contraceptive implant services, unless another separate and distinct service is provided and documented in the recipient's medical record.

Indicate CPT code 11975, 11976, or 11977, type of service (TOS) "2" (surgery), on the claim.

### *Informed Consent Procedure*

Wisconsin Medicaid recommends that providers of implantable contraceptives have a fully informed consent procedure and present comprehensive information to recipients prior to the implantation procedure. This information should include the following:

- Physiological effects of contraceptive implants.
- Risks associated with implant use.
- Potential side effects.
- Recommendations for follow-up care and removal.

As part of the informed consent process, the Division of Health Care Financing recommends using information provided in the patient education materials supplied by the manufacturer. Recipients should be informed of the following considerations:

- Some patients may experience thick, permanent scarring of the skin at the insertion and removal site (keloid formation).
- Migration of the capsules may occur making removal difficult.
- Women can request the implant be removed at any time.
- The implant does not provide protection against sexually transmitted diseases.

Wisconsin Medicaid recommends providing a waiting period between the education session and the insertion of the implant, as it may help ensure that a proper amount of time is allowed for an informed decision. Some providers indicate that this allows increased recipient

acceptance of the implant. Such a waiting period may not always be acceptable, however, considering factors such as recipient preferences and limited transportation.

### *Informed Consent Documentation*

Informed consent should be documented in the recipient's medical record and must include the signatures or initials of both the provider and the recipient.

## Dilation and Curettage

Wisconsin Medicaid requires a second opinion for dilation and curettage, diagnostic or therapeutic (nonobstetrical), when performed on an elective basis. Refer to Appendix 3 of this handbook for a Second Opinion Elective Surgery Request/Physician Report form.

## Hysterectomies

Wisconsin Medicaid reimbursement for a hysterectomy is denied when performed for uncomplicated fibroids, a fallen uterus, or a retroverted uterus.

Reimbursement for a hysterectomy requires both a second surgical opinion and the completion of the Acknowledgement of Receipt of Hysterectomy Information form. Refer to Appendix 3 of this handbook for second surgical opinion information and Appendix 5 of this handbook for information about the Acknowledgement of Receipt of Hysterectomy Information form.

### *Acknowledgement of Receipt of Hysterectomy Information Form*

Except in the situations noted in this section, an Acknowledgement of Receipt of Hysterectomy Information form is required to be completed prior to the surgery and attached to the CMS 1500 claim form. Providers may develop a form of their own, as long as it includes all the same information as the Wisconsin Medicaid form. Refer to Appendix 5 of this handbook for a copy of the form.

A hysterectomy may be covered without a valid acknowledgement form if one of the following circumstances applies:

- The recipient was already sterile. This may include menopause. (The physician must state the cause of sterility.)
- The hysterectomy was required as the result of a life-threatening emergency situation, in which the physician determined that a prior acknowledgement of receipt of hysterectomy information was not possible. (The physician must describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive recipient eligibility and one of the following circumstances applied:
  - √ The recipient was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  - √ The recipient was already sterile.
  - √ The recipient was in a life-threatening emergency situation which required a hysterectomy.

For all of these exceptions, the physician must identify the applicable circumstance in writing in signed and dated documentation attached to the CMS 1500 claim form. (A copy of the preoperative history/physical exam and operative report is usually sufficient.)

Refer to Appendix 5 of this handbook for an Acknowledgement of Receipt of Hysterectomy Information form.

## Intrauterine Devices

Wisconsin Medicaid reimburses family planning clinics separately for the IUD and for insertion and removal procedures. Reimbursement for the E&M office visit and for necessary supplies (other than the IUD itself) is included in the reimbursement for the IUD insertion and removal procedures, unless another separate and distinct service is provided and documented in the recipient's medical record.



Wisconsin Medicaid reimburses family planning clinics separately for the IUD and for insertion and removal procedures.

Wisconsin Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements cited below and satisfactory completion of a Sterilization Informed Consent form.

Use the following procedure codes to bill for IUD insertion and removal procedures:

*Intrauterine Device*

J7300 (TOS "1") Intrauterine copper contraceptive.
J7302 (TOS "1") Levonorgestrel-releasing intrauterine contraceptive system, 52 mg.
W6200 (TOS "1") IUD — progesterone.

*Intrauterine Device Insertion/Removal*

58300 (TOS "2") Insertion of IUD.
58301 (TOS "2") Removal of IUD.

## Sterilizations

### *General Requirements*

A sterilization is any surgical procedure performed with the primary purpose of rendering an individual permanently incapable of reproducing. This does not include procedures that, while they may result in sterility, have a different purpose, such as surgical removal of a cancerous uterus or cancerous testicles.



Wisconsin Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements cited below and satisfactory completion of a Sterilization Informed Consent form. There are no exceptions. Federal and state regulations require the following:

- The recipient is not an institutionalized individual.
- The recipient is at least 21 years old on the date the informed written consent is obtained.
- The recipient gives voluntary informed written consent for sterilization.
- The recipient is not a mentally incompetent individual. Wisconsin Medicaid defines a "mentally incompetent" individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery or:
  - √ In the case of premature delivery, the sterilization is performed at the time of premature delivery and written informed consent was given at least 30 days before the expected date of delivery and at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
  - √ The sterilization is performed during emergency abdominal surgery and at least 72 hours have passed since the recipient gave written informed consent for sterilization.

### *Sterilization Informed Consent Form*

The recipient must give voluntary written consent on the federally required Sterilization Informed Consent form. Sterilization coverage requires accurate and thorough completion of the consent form. The physician is responsible for obtaining consent. Refer to Appendices 6 and 7 of this handbook for the Sterilization Informed Consent form completion instructions and a blank copy of the form for photocopying. Any corrections to the form, once completed, must be signed and dated by the physician and/or recipient, as appropriate.

Signatures and signature dates of the recipient, physician, and the person obtaining the consent are mandatory. Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.

To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent form before *all* sterilizations (i.e., Medicaid and non-Medicaid recipients) in

the event that a patient obtains Medicaid retroactive eligibility.

Physicians must attach the completed consent form to the CMS 1500 claim form to obtain reimbursement. Because an attachment is necessary, this claim cannot be submitted electronically.

Obtain consent forms at Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/* or by writing to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

# Laboratory and Radiology Services

## Laboratory/Diagnostic Services

Laboratory services are Medicaid-covered family planning clinic services, as stated in HFS 107.21(1)(c), Wis. Admin. Code. Laboratory services may be reimbursed separately when performed in conjunction with initial or annual examinations with health history (CPT procedure codes 99201-99205 [new patient] and 99211-99215 [established patient]) or other office or antepartum visits. A list of family planning covered laboratory procedure codes is included in Appendix 1 of this handbook.

### *Coverage of Routinely Performed Laboratory Services*

Wisconsin Medicaid reimburses family planning clinics for the following routinely performed laboratory services when medically necessary:

- Bacterial smear or culture (gonorrhea, trichomonas, yeast, etc.) including syphilis serology with positive gonorrhea cultures (VDRL).

*Note*: Syphilis serology and gonorrhea tests are to be treated as separate procedures. A gonorrhea test does not necessarily have to be performed in conjunction with syphilis serology. However, a VDRL serology should be done if a gonorrhea test is positive.

- Blood glucose test.
- Complete blood cell count.
- Hematocrit.
- Hemoglobin.
- Papanicolaou smear (for females between the ages of 12 and 65).
- Serology.
- Urinanalysis.

### *Laboratory Services with Restricted Coverage*

The following laboratory services are covered for family planning clinics only if justified by the recipient's health history:

- Blood test for cholesterol, triglycerides when related to oral contraceptive prescriptions.
- Colposcopy (may be used as either diagnostic or treatment procedures).
- Microscopic analysis of urine.
- Post-prandial blood glucose.
- Pregnancy test.
- Rubella titer.
- Sickle-cell screening.
- Skin test for tuberculosis.
- Vaginal smears and wet mounts for suspected vaginal infection.

Wisconsin Medicaid covers the following laboratory procedures *only* when they are for purposes other than the treatment or diagnosis of fertility-related conditions:

- Basal body temperature monitoring.
- Cervical mucus exam.
- Endometrial biopsy (when performed after hormone blood test).
- Hysterosalpingogram.
- Laparoscopy (may be used as either diagnostic or treatment procedures).
- Semen analysis and motility studies (includes pelvic exam as necessary).



To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent form before *all* sterilizations (i.e., Medicaid and non-Medicaid recipients) in the event that a patient obtains Medicaid retroactive eligibility.

### *Coverage of Laboratory Services Relating to Genetics*

Covered family planning clinic laboratory procedures relating to genetics are limited to the following:

- Amniocentesis.
- Chromosome analysis.
- Cystic Fibrosis.
- Down Syndrome.
- Hemophilia testing.
- Muscular Dystrophy screening.
- Sickle-cell screening.
- Tay-Sachs screening.
- Ultrasound.

### *Laboratory Services Incidental to a Noncovered Abortion*

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include laboratory testing and interpretation.



## Radiology Services

Radiology services are Medicaid-covered family planning services. Refer to Appendix 1 of this handbook for a list of Medicaid-allowable radiology codes.

Refer to the Laboratory and Radiology section of the Physician Services Handbook for further information about radiology services coverage. The Physician Services Handbook can be accessed from Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.

## Complete Procedure vs. Professional and Technical Components

Most radiology and some laboratory service procedure codes consist of technical and professional components that are separately reimbursable. Family planning clinics may be reimbursed for these procedure codes as "complete" procedures when they perform both professional and technical components of the procedures.

Most radiology and some laboratory service procedure codes consist of technical and professional components that are separately reimbursable.

Use the following guidelines to determine whether to indicate a complete procedure or to indicate separate technical or professional components when submitting claims for laboratory and radiology services.

### *Laboratory Services*

Most laboratory services are performed and reimbursed as a complete procedure (TOS "5"). Claims for laboratory procedures should be submitted as a complete procedure (TOS "5") when both the technical and professional components are performed by a single laboratory.

A *written report* must be produced and maintained in the recipient's medical record when procedure codes with both technical and professional components are submitted with either a TOS "X" or "5."

At times, the technical component may be performed by the clinic, but the professional component is performed by an outside physician or laboratory. In these situations, each provider submits claims and is reimbursed only for the service performed, as follows:

- The provider performing the technical component indicates only the technical component (TOS "U").
- The provider performing the professional component indicates only the professional component (TOS "X"). Remember that the professional component must result in a written report that is kept in the recipient's medical record.

The complete procedure (TOS "5") is not reimbursable to either provider in this situation.

The attending physician's clinical interpretation of laboratory results is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician's E&M service.

*Radiology Services*

Family planning clinic providers may be reimbursed for a complete procedure when performing both the professional and technical components of radiologic procedures, or supervising others who do so in the office, clinic, or other nonhospital setting (TOS "4," "6," or "K," as appropriate).

A *written report* regarding the analysis and interpretation of radiologic test results is required for Wisconsin Medicaid reimbursement of the professional component of radiologic services. This report must be kept as part of the recipient's medical record.

If the place of service (POS) is a hospital setting (inpatient, POS "1" or outpatient, POS "2"), or if the technical portion is performed by a portable X-ray provider, the clinic may be reimbursed for the professional component only, but not for the complete procedure. The technical component is reimbursed to the hospital or provider of portable X-ray services.

Family planning clinics that perform only the technical component of radiologic services are reimbursed by Wisconsin Medicaid for the technical component only. The outside provider performing the professional component of the service is reimbursed only for the professional component.

## Supplies

The following family planning supply items are separately reimbursable covered services when prescribed by a physician or nurse practitioner:

- Condoms, per unit.
- Contraceptive pills.
- Diaphragms.
- Intrauterine copper contraceptive.
- Intrauterine device (progesterone).
- Jellies, creams, and foams, per unit.
- Natural family planning supplies (charts for determining fertility).
- Suppositories, per unit.

Wisconsin Medicaid does not separately reimburse family planning clinics for any other supplies, medications, or devices. Refer to Appendix 1 of this handbook for Medicaid-allowable family planning procedure codes.



### Diaphragms

The following procedures relating to diaphragms are covered:

- The diaphragm.
- Providing and fitting the device.
- Follow-up office visit once within 90 days of providing and fitting.

  *Note:* When an office visit is billed on the same day as providing and fitting of the diaphragm (57170), Wisconsin Medicaid denies the office visit and reimburses the providing and fitting of the diaphragm, except when the office visit is for a separate identifiable medical problem.

A *written report* regarding the analysis and interpretation of radiologic test results is required for Wisconsin Medicaid reimbursement of the professional component of radiologic services.

# Noncovered Services

As specified in HFS 107.03 and 107.21(3), Wis. Admin. Code, the following family planning-related services are not covered by Wisconsin Medicaid:

1. Services, drugs, and items that are provided for the purpose of enhancing the prospects of fertility in males or females, including, but not limited to, the following:
   - Artificial insemination, including, but not limited to, intracervical and intrauterine insemination.
   - Infertility counseling.
   - Infertility testing, including, but not limited to, tubal patency, semen analysis, or sperm evaluation.
   - Reversal of female sterilization, including, but not limited to, tubouterine implantation, tubotubal anastomoses, and fimbrioplasty.
   - Reversal of vasectomies.
   - Drugs that enhance fertility when used specifically for the treatment of infertility.
   - Office visits, consultations, and other encounters to enhance the prospects of fertility.
   - Other fertility-enhancing services and items.
2. Surrogate parenting and related services, including, but not limited to, artificial insemination and subsequent obstetrical care.
3. Impotence treatment drugs, devices, and services, including, but not limited to, penile prostheses and external devices, insertion surgery, and other related services.
4. Services, including drugs, related to nonsurgical abortions that do not comply with current state abortion statutes (s. 20.927, Wis. Stats.).

# Preparing Claims

## Claims Submission

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

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee established by the Department of Health and Family Services for the procedure code.

### Electronic Claims Submission

Family planning clinic providers are encouraged to submit claims electronically. Electronic claims submission:

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

Wisconsin Medicaid provides free software for electronic claims submission. For more information about electronic claims submission:

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



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

### Paper Claims Submission

Providers submitting paper claims must use the CMS 1500 claim form (dated 12/90). Appendix 9 of this handbook contains a completed sample of a CMS 1500 claim form for family planning clinic services. Refer to Appendix 8 of this handbook for CMS 1500 claim form completion instructions.

Wisconsin Medicaid denies claims for family planning clinic services submitted on any other paper claim form than the CMS 1500 claim form.

Wisconsin Medicaid does not provide the CMS 1500 claim form. You may obtain the form from any vendor who supplies federal forms.

### Where to Send Your Claims

Mail completed CMS 1500 claim forms to the following address:

Wisconsin Medicaid
Claims and Adjustment
6406 Bridge Rd
Madison WI 53784-0002

### Claims Submission Deadline

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

Exceptions to the 365-day claims submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at *www.dhfs.state.wi.us/medicaid/*.

## Reimbursement

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee established by the Department of Health and Family Services for the procedure code.

Obtain a family planning maximum fee schedule by using one of the following methods:

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider

Handbook. Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

- Purchase a paper schedule by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

## Billed Amounts

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

Providers may not discriminate against Wisconsin Medicaid recipients by charging Wisconsin Medicaid a higher fee for the same service than that charged to a private-pay patient. For providers who have not established usual and customary charges, the usual and customary fee should be reasonably related to the cost of providing the service.

## Procedure Codes

Use the single five-character *Current Procedural Terminology* (CPT) procedure code, Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System, code, or approved local procedure code that best describes the service performed. Wisconsin Medicaid denies claims received without an appropriate CPT, HCPCS, or local code. Refer to Appendix 1 of this handbook for a list of Medicaid-allowable family planning procedure codes.

Do not use multiple procedure codes to describe a single service.

### McKesson ClaimCheck® Monitors Medicaid Policy

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to CPT codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

For further information about ClaimCheck, refer to Appendix 10 of this handbook.



## Diagnosis Codes

All claims submitted for family planning clinic services must include an appropriate diagnosis code from the *International Classification of Diseases, Ninth Edition, Clinical Modifications* (ICD-9-CM) coding structure. Wisconsin Medicaid denies claims received without an appropriate ICD-9-CM coding structure.

Refer to the Provider Resources section of the All-Provider Handbook for information about ordering the ICD-9-CM code book.

## Family Planning Indicator

Wisconsin Medicaid requires providers to enter a family planning indicator in Element 24H of the CMS 1500 claim form for family planning services. Refer to Appendix 8 for information on completing the CMS 1500 claim form.

For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to patients who are ineligible for subsidized services.

# Appendix

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# Appendix 1
# Wisconsin Medicaid-Allowable Family Planning Procedure Codes and Descriptions

| Evaluation and Management Services | Procedure Codes | Type of Service (TOS) |
|---|---|---|
| Office or Other Outpatient Services | 99201-99215 | 9 |
| Preventive Medicine Services | 99384-99387, 99394-99397 | 1 |

| Medicine Services | Procedure Codes | TOS |
|---|---|---|
| Immune Globulins | 90384-90386 | 1 |
| Intramuscular injection of antibiotic | 90788 | 1 |
| Cardiovascular | 93000 | B |
| | 93010 | W |
| Special Services, Procedures and Reports | 99000 | 9 |

| Surgery Services | Procedure Codes | TOS |
|---|---|---|
| Contraceptive implants | 11975-11976 | 2, 8 |
| | 11977 | 2 |
| Male Genital System | 54050 | 2 |
| | 55250* | 2, 7, 8 |
| | 55450* | 2, 8 |
| Female Genital System | 56440, 56501, 56605, 56606, 57061, 57170, 57452 | 2 |
| | 57454 | 2, 8 |
| | 57500 | 2 |
| | 58100-58120 | 2, 7, 8 |
| | 58300-58301 | 7, 9 |
| | 58600*, 58605*, 58615* | 2, 7, 8 |
| | 59000 | 2 |
| | 59840-59851** | 2, 7, 8 |



| Radiology Services | Procedure Codes | TOS |
|---|---|---|
| Chest | 71010-71022, 71030-71035 | 4, Q, U |
| Spine and pelvis | 72170, 72190, 72200, 72202 | 4, Q, U |
| Abdomen | 74000-74020 | 4, Q, U |
| Gynecological and obstetrical | 74710 | 4, Q, U |
| Veins and lymphatics | 76078 | 4 |
| | 76090, 76091 | 4, Q, U |
| Abdomen and retroperitoneum | 76705 | 4, Q, U |

* Requires Sterilization Informed Consent form. Refer to Appendices 6 and 7.

** There are limitations to these services. Refer to “Abortions” under “Surgery Services” in the Covered Services chapter of this handbook.

**Appendix 1**
**(Continued)**

| Radiology Services (continued) | Procedure Codes | TOS |
|---|---|---|
| Pelvis | 76805 | 4, Q |
| | 76815 | 4, Q |
| | 76856 | 4, Q |
| Extremities | 76885-76886 | 4 |
| Ultrasonic guidance procedures | 76946, 76970 | 4, Q |

| Laboratory Services | Procedure Codes | TOS |
|---|---|---|
| Organ or Disease Oriented Panels | 80050, 80055-80061 | 5 |
| Urinalysis | 81000 | 5, 9 |
| | 81002, 81005, 81015, 81025 | 5 |
| Chemistry | 82042, 82143, 82310, 82330, 82435, 82465, 82520, 82565, 82575, 82607, 82671-82677, 82728, 82746, 82947-82948 | 5 |
| | 83020 | 5, X |
| | 83030-83033, 83045, 83518, 83540-83550, 83582-83593, 83655, 83715, 83718-83719, 83727, 83840, 83887-83890, 83892, 83894-83896, 83898, 83902, 84132, 84135, 84144-84146, 84295, 84315, 84403-84425, 84436-84445, 84478-84481, 84702-84703 | 5 |
| Hematology and Coagulation | 85002-85007, 85009-85018, 85022, 85027-85041, 85060, 85651, 85660 | 5 |
| Immunology | 86280, 86310, 86580-86585, 86592-86593, 86631, 86689, 86694-86695, 86701, 86703, 86706, 86762-86765, 86781, 86787, 86800 | 5 |
| Transfusion Medicine | 86850, 86900-86901 | 5 |
| Microbiology | 87040, 87070, 87081, 87086, 87088, 87101, 87102, 87118, 87205, 87210, 87270, 87274, 87320, 87340, 87350, 87380, 87390-87391, 87449, 87485-87492, 87510-87517, 87528, 87530-87539, 87590-87591, 87620-87652, 87798-87799 | 5 |
| Cytopathology | 88141-88152, 88155-88161 | 5, U, X |
| Cytogenetic Studies | 88261-88267, 88280 | 5 |
| Other Procedures | 89300-89320, 89350 | 5 |

## Appendix 1
## (Continued)

| Supplies | Procedure Codes | TOS |
|---|---|---|
| Injection, ceftriaxone sodium, (Rocephin), per 250 mg | J0696 | 1 |
| Injection, medroxyprogesterone acetate for contraceptive use, 150 mg | J1055 | 1 |
| Depo-medroxyprogesterone, 150 mg | W6117 | 9 |
| Intrauterine device, progesterone | W6200 | 9 |
| Intrauterine copper contraceptive | J7300 | 9 |
| Levonorgestrel-releasing intrauterine contraceptive system, 52 mg | J7302 | |
| Diaphragm | W6201 | 9 |
| Jellies, creams, foams | W6202 | 9 |
| Suppositories (per 1) | W6203 | 9 |
| Sponges (per 1) | W6204 | 9 |
| Condoms (per 1) | W6205 | 9 |
| Natural family planning supplies | W6206 | 9 |
| Oral contraceptives | W6207 | 9 |
| Female condom | W6208 | 9 |
| Cervical cap | W6209 | 9 |
| Mifepristone, oral, 200 mg | S0190** | 1 |
| Misoprostol, oral, 200 mcg | S0191** | 1 |
| Norplant | 11975 | 9 |



| Other Services | Procedure Codes | TOS |
|---|---|---|
| Family planning pharmacy visit including oral contraceptives | W6210 | 9 |
| Initial visit, non-comprehensive | W6211 | 9 |
| Annual visit, non-comprehensive | W6212 | 9 |

** There are limitations to these services. Refer to “Coverage of Mifeprex” in the Covered Services chapter of this handbook.

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# Appendix 2
# Medicaid Type of Service and Place of Service Codes

| Type of Service (TOS) Codes | |
|---|---|
| **TOS** | **Description** |
| 1 | Medical care, injections, HealthCheck (ESPDT) |
| 2 | Surgery |
| 4 | Diagnostic X-ray (total charge)/Ultrasound (total charge) |
| 5 | Diagnostic laboratory (total charge), HealthCheck laboratory |
| 7 | Anesthesia |
| 8 | Assistant surgery |
| 9 | Other: family planning |
| B | Diagnostic testing, diagnostic medical services — total or complete procedure including professional and technical components |
| Q | Diagnostic X-ray — professional/Ultrasound — professional |
| U | Diagnostic testing, diagnostic medical services — technical component only |
| W | Diagnostic testing, diagnostic medical services — professional component only (interpretation) |
| X | Diagnostic laboratory service — professional |



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

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## Appendix 3
## Second Opinion Elective Surgery Request/Physician Report (for photocopying)

(A copy of the Second Opinion Elective Surgery Request/Physician Report is located on the following page.)

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**WISCONSIN MEDICAID**

# SECOND OPINION ELECTIVE SURGERY REQUEST / PHYSICIAN REPORT

Wisconsin Medicaid requires 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.

**INSTRUCTIONS:** All Medicaid recipients, with the exception of recipients enrolled in a Medicaid HMO or in emergent, urgent, or waiver situations, are required to obtain a second surgical opinion (SSO) before having one of the surgical procedures listed in the Medicine and Surgery section of the Physician Services Handbook on an elective basis.

The ultimate responsibility for the decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second opinion physician agrees or disagrees with the recommending surgeon.

## SECTION I — RECOMMENDING SURGEON INFORMATION

Date (MM/DD/YY)

Note: The recommending surgeon must complete Section I of the form before sending the form to the second opinion physician.

Check One

- ❑ I would like the second opinion physician to send this form back to me.
- ❑ I would like the second opinion physician to send this form directly to Wisconsin Medicaid.



**Recipient (Patient) Information**

| Name — Recipient | Wisconsin Medicaid Identification Number (10 digits) | |
|---|---|---|
| Address (Street / P.O. Box) | | |
| City | State | Zip Code |
| Telephone Number | County | |
| Birth Date (MM/DD/YY) | Gender ❑ Female ❑ Male | |

**Recommending Surgeon (mailing address)**

| Name — Recommending Surgeon | Wisconsin Medicaid Provider Number (eight digits) | |
|---|---|---|
| Address (Street) | | |
| City | State | Zip Code |
| Telephone Number | | |

*Continued on reverse*

**Specify whether someone other than the recipient (parent, relative, guardian, etc.) should be contacted concerning the second opinion.**

| Name — Contact Person | Telephone Number |
|---|---|
| Address (Street) | |

| City | State | Zip Code |
|---|---|---|

**Primary / Referring Physician (if different from above)**

Name — Primary / Referring Physician

Address (Street)

| City | State | Zip Code |
|---|---|---|

**Check Proposed Procedure**

- ❑ Cataract extraction and/or intraocular lens implant (❑ check if bilateral)
- ❑ Cholecystectomy
- ❑ D&C (diagnostic)
- ❑ Hemorrhoidectomy
- ❑ Hernia repair (❑ check if bilateral)
- ❑ Hysterectomy
- ❑ Joint replacement — hip (❑ check if bilateral)
- ❑ Joint replacement — knee (❑ check if bilateral)
- ❑ Tonsillectomy and/or adenoidectomy
- ❑ Varicose vein surgery



| **SIGNATURE** — Recommending Surgeon | Date Signed |
|---|---|

**SECTION II — SECOND OPINION PHYSICIAN INFORMATION**

Note: The physician performing the second opinion must complete this section of the form.

| Name — Performing Physician | Wisconsin Medicaid Provider Number (eight digits) |
|---|---|
| Address (Street) | |

| City | State | Zip Code |
|---|---|---|

Findings (include any information on alternative treatment, additional medical tests, or other significant findings)

❑ These findings and options / alternatives were presented to the recipient.

Check One
- ❑ I agree with the need for the surgery.
- ❑ I do not agree with the need for the surgery.

Comments

| **SIGNATURE** — Second Opinion Physician | Date Signed |
|---|---|

**Distribution:** Following the recommending surgeon's request indicated on the front page, return this form to either the recommending surgeon whose name and address are listed on the front page, or mail to:

Wisconsin Medicaid
SSO Dept
6406 Bridge Rd
Madison WI 53784-0012

## Appendix 4
## Abortion Certification Statements (for photocopying)

(A copy of the Abortion Certification Statements is located on the following page.)

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Refer to the Online Handbook
for current policy

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 1161 (Rev. 01/03)

**STATE OF WISCONSIN**
s. 20.927, Wis. Stats.

## WISCONSIN MEDICAID
# ABORTION CERTIFICATION STATEMENTS

Wisconsin Medicaid requires 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.

**Coverage Policy**
In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred, ***and*** provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.



**INSTRUCTIONS:** When filing a claim for reimbursement of an abortion with Wisconsin Medicaid, physicians must attach a written certification statement attesting to one of the circumstances below. The following are sample certification statements that providers may use to certify the medical necessity of the abortion. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

## SECTION I — LIFE OF THE MOTHER

I, _____ , certify that
(Name — Provider)

on the basis of my best clinical judgement, abortion is directly and medically necessary to save the life of

_____ , of
(Name — Recipient)

_____ ,
(Address — Recipient)

for the following reasons:

_____

_____ .

_____ _____
**SIGNATURE** — Physician Date Signed

*Continued on reverse*

**SECTION II — VICTIM OF RAPE OR INCEST**

I, _____ , certify that it is my belief that
(Name — Provider)

_____ , of
(Name — Recipient)

_____ , was the victim of rape (or incest).
(Address — Recipient)

_____ _____
**SIGNATURE** — Physician Date Signed

**SECTION III — GRAVE AND LONG-LASTING DAMAGE TO PHYSICAL HEALTH**

I, _____, certify on the basis of
(Name — Provider)



my best clinical judgement that due to an existing medical condition grave, long-lasting physical health damage to

_____ , of
(Name — Recipient)

_____ ,
(Address — Recipient)

would result if the pregnancy were carried to term. The following medical condition necessitates the abortion (specify the medical condition/diagnosis):

_____

_____

_____ _____
**SIGNATURE** — Physician Date Signed

## Appendix 5
## Acknowledgement of Receipt of Hysterectomy Information (for photocopying)

(A copy of the Acknowledgement of Receipt of Hysterectomy Information is located on the following page.)

## WISCONSIN MEDICAID
# ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Wisconsin Medicaid requires 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.

**INSTRUCTIONS:** The Acknowledgement of Receipt of Hysterectomy Information form is to be completed by a physician before performing the surgery and attached to the CMS 1500 claim form. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

Medicaid reimbursement for a hysterectomy requires both a second surgical opinion and the completion of this form or similar form with the same information. This form is not to be used for purposes of consent of sterilization. A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form.

**Name — Recipient**
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. The name in this element must match the name on the claim.

**Address — Recipient**
Enter the recipient's address. Use the EVS to obtain the address.

**Recipient's Medicaid ID No.**
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. This identification number must match the identification number on the claim.



**Name — Physician**
Enter the performing provider's name.

**Physician's Medicaid Provider No.**
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

**Name — Recipient**
Enter the recipient's name. The name in this element must match the recipient's name entered at the top of the form.

**Signatures — Recipient, Representative, and Interpreter**
Recipient — The recipient must sign and date this element. (Signing this form does not require the recipient to undergo the hysterectomy surgery.)

Representative — The representative must sign and date this element if a representative was required for the recipient.

Interpreter — An interpreter must sign and date this element if the recipient does not understand the language used on the form and if an interpreter was used to translate this information.

**Date Signed**
Enter the date the recipient signs the Acknowledgement of Receipt of Hysterectomy Information form in this element. This date must be ***on or before*** the date of service on the claim.

*Continued on reverse*

## Appendix 6
## Sterilization Informed Consent Form Instructions (for photocopying)

(A copy of the Sterilization Informed Consent Form Instructions is on the following page. A sample consent form is included following the instructions.)

## WISCONSIN MEDICAID
# STERILIZATION INFORMED CONSENT FORM INSTRUCTIONS

Wisconsin Medicaid requires 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 Wisconsin 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 mandatory in order for Wisconsin Medicaid to reimburse providers for services. Any corrections to the form must be signed by the physician and/or recipient, as appropriate. The use of opaque correction fluids on the Sterilization Informed Consent form is prohibited. Instead, strike the incorrect information and initial the corrected information.

### CONSENT TO STERILIZATION

The person who obtains the informed consent must provide orally all of the requirements for the informed consent as listed on the consent form, must offer to answer any questions, and must provide a copy of the consent form to the recipient to be sterilized for consideration during the waiting period. (The person obtaining consent need not be the physician performing the procedure.)

Suitable arrangements must be made to ensure that the required information is effectively communicated to the recipient to be sterilized if he or she is blind, deaf, or otherwise handicapped.

**Element 1 — Doctor or Clinic (required)**
The physician named in Element 1 is not required to match Elements 5 or 23. A recipient may receive information from one doctor/clinic and be sterilized by another. Corrections to this field must be initialed by the person obtaining consent or the physician.



**Element 2 — Procedure (required)**
The information given in Element 2 must be comparable, but not necessarily identical, to Elements 6, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

**Element 3 — Date of Birth (required)**
Recipient's date of birth. The month, day, and year must be clearly indicated. Corrections to this field must be lined through and initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

**Element 4 — Name of Recipient (required)**
The recipient's name must be legible. ***Initials are acceptable for the first and/or middle name only.*** The name may be typed. If this element does not match the signature in Element 7, check the Eligibility Verification System (EVS) to verify that this is the same person. Consider the name in Element 4 to be the valid name. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

**Element 5 — Doctor (required)**
The name of the doctor, affiliates, or associates is acceptable. The physician in Element 5 is not required to match Element 1 or 23. Corrections to this element must be initialed by the person obtaining consent or the physician. (A consent form *is* transferable and does ***not*** necessitate a new 30-day waiting period.)

**Element 6 — Procedure (required)**
The information given in Element 6 must be comparable, but not necessarily identical to Elements 2, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

**Element 7 — Signature (required)**
The recipient's signature does not need to ***exactly*** match the name in Element 4. It is unacceptable for the recipient's signature to be ***completely*** different from the name in Element 4. Initials are acceptable for the first and/or middle name. An "X" is acceptable as a signature *if* a witness of the recipient's choice has signed the form. The individual obtaining consent may not act as a witness. There is no field on the form for a witness' signature; it should appear directly below the recipient signature element and be followed by the date of witness, which must match the recipient's signature date in Element 8. Corrections to Element 7 must be initialed by the recipient. (A correction does ***not*** require a new 30-day waiting period.)

**Element 8 — Date (required)**
The recipient must be at least 21 years old on this date. If the signature date is the recipient's 21st birthday, the claim is acceptable. At least 30 days but not more than 180 days, excluding the consent and surgery dates, must have passed between the date of the written informed consent and the date of sterilization, except in the case of premature delivery. Corrections to this field must be initialed by the recipient. (A correction does ***not*** require a new 30-day waiting period.)

**Element 9 — Race and Ethnic Designation (not required)**

## INTERPRETER'S STATEMENT

An interpreter must be provided to assist the recipient if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent.

**Elements 10 to 12 — Language, Interpreter, Date**
If applicable, the date the interpreter signs can be on or prior to the recipient's signature date in Element 8.



## STATEMENT OF PERSON OBTAINING CONSENT

**Element 13 — Name of Recipient (required)**
The recipient's name does not need to ***exactly*** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

**Element 14 — Procedure (required)**
The information given in Element 14 must be comparable, but not necessarily identical, to Elements 2, 6, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

**Elements 15 to 18 — Signature of Person Obtaining Consent, Date, Facility, Address (required)**
The person obtaining the consent may be, but is not required to be, the physician performing the procedure. A facility and/or facility address must be indicated, but only one (of the provider's choice) is required. Additionally, the signature date (Element 16) can be prior to, on, or after the date the recipient signs (Element 8). Corrections to this field must be initialed by the person obtaining consent.

## PHYSICIAN'S STATEMENT

**Element 19 — Name of recipient (required)**
The recipient's name does not need to ***exactly*** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This does ***not*** require a new 30-day waiting period.)

**Element 20 — Date of sterilization (required)**
The date must match the date of service (DOS) on the claim. Reimbursement is not allowed unless at least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of the sterilization. This means the DOS must be at least the 31st day after the recipient signature date and no later than the 181st day after that date. Neither the date of informed consent nor the date of surgery will be counted as part of the 30-day requirement. In cases of premature delivery, the consent form must have been signed at least 30 days prior to the expected date of delivery as identified in Element 22 and at least 72 hours must have passed before premature delivery. In cases of emergency abdominal surgery, at least 72 hours must have passed from the date the recipient gave informed consent to be sterilized. Element 22 must be completed in the case of premature delivery or emergency abdominal surgery. Corrections to this field must be initialed by the physician.

**Element 21 — Specify type of operation (required)**
Must be comparable to Elements 2, 6, and 14 or state "same." If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

**Element 22 — Exception to 30-Day Requirement (required if less than 31 days have passed between date of signed consent and sterilization date)**
The individual's expected date of delivery must be stated in the case of premature delivery. In the case of emergency abdominal surgery, the circumstances must be described. Corrections to this field must be initialed by the physician.

**Element 23 — Physician Signature and Date (required)**
- _____ Alterations to this field must be initialed by the physician.
- _____ Initials may be used in the signature for the first and/or middle name only.
- _____ A signature stamp or computer-generated signature is not acceptable.
- The physician's signature on the consent form does not need to exactly match the ***performing*** physician's name on the claim form. It is unacceptable for the physician's signature to be completely different from the name on the claim.
- Physician's signature date must be on or after the date the sterilization was performed.
- _____ A nurse or other individual's signature is not acceptable.

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 1164A (Rev. 01/03)

**STATE OF WISCONSIN**
HFS 107.06(3)(e), Wis. Admin. Code

## WISCONSIN MEDICAID
# STERILIZATION INFORMED CONSENT

**NOTICE:** YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

### ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from **1** (*doctor or clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an **2**. The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally-funded programs.

I am at least 21 years of age and was born on **3** (*Month Day Year*).

I, **4**, hereby consent of my own free will to be sterilized by **5** (*doctor*) by a method called **6**. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare, or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

**7** Date **8**
***SIGNATURE*** *— Recipient* *Month Day Year*

You are requested to supply the following information, but it is not required:

*Race and ethnicity designation* (please check)

**9**
- ❑ American Indian or Alaska native
- ❑ Asian or Pacific Islander
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ White (not of Hispanic origin)

### ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in **10** language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

**11** **12**
***SIGNATURE*** *— Interpreter* *Date Signed*

### ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before **13** (*name of individual*) signed the consent form, I explained to him/her the nature of the sterilization operation **14**, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

**15** **16**
***SIGNATURE*** *— Person Obtaining Consent* *Date Signed*

**17**
*Facility*

**18**
*Address*

### ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon **19** (*Name of individual to be sterilized*) on **20** (*Date of sterilization*), I explained to him/her the nature of the sterilization operation _____ (*operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

**(Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

**22**
- ❑ Premature delivery
- ❑ Individual's expected date of delivery: _____
- ❑ Emergency abdominal surgery:

(describe circumstances): _____

_____

**23**
***SIGNATURE*** *— Physician* *Date Signed*

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Refer to the Online Handbook
for current policy

## Appendix 7
## Sterilization Informed Consent (for photocopying)

(A copy of the Sterilization Informed Consent is located on the following page.)

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 1164 (Rev. 01/03)

**STATE OF WISCONSIN**
HFS 107.06(3)(e), Wis. Admin. Code

# WISCONSIN MEDICAID
# STERILIZATION INFORMED CONSENT

**NOTICE:** YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

## ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*doctor or clinic*) . When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an _ _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally-funded programs.

I am at least 21 years of age and was born on _____. *Month Day Year*

I, _____ , hereby consent of my own free will to be sterilized by _____ (*doctor*) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare, or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
***Signature*** *– Recipient* *Month Day Year*

You are requested to supply the following information, but it is not required:

*Race and ethnicity designation* (please check)

☐ American Indian or Alaska native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

## ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
***Signature*** *– Interpreter* *Date*

## ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*name of individual*) signed the consent form, I explained to him/her the nature of the sterilization operation _____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
***Signature*** *— Person Obtaining Consent* *Date*

_____
*Facility*

_____
*Address*



## ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of individual to be sterilized*) on _____ (*Date of sterilization*) _____ (*operation*), I explained to him/her the nature of the sterilization operation _____ (*specify type of operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

**(Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
☐ Individual's expected date of delivery:_____
☐ Emergency abdominal surgery:

(describe circumstances):_____

_____

_____
***Signature*** *– Physician* *Date*

# Appendix 8
# CMS 1500 Claim Form Completion Instructions

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

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

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

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

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

Enter the recipient's 10-digit Medicaid 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. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

### Element 3 — Patient's Birth Date and Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female by placing an "X" in the appropriate box.



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

### Element 5 — Patient's Address

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

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

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

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

### Element 9 — Other Insured's Name (not required)

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

### Element 11— Insured's Policy Group or FECA Number (not required)

### Elements 12 and 13 — Authorized Person's Signature (not required)

### Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

### Element 15 — If Patient Has Had Same or Similar Illness (not required)

### Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

### Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

For procedure codes that require a referring physician, enter the referring or prescribing physician's name in Element 17 and six-character Universal Provider Identification Number (UPIN) in Element 17a. 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

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be given in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19. Do not bill unlisted procedure codes through electronic billing. Unlisted procedure codes are required to be submitted through paper claims submission.

### Element 20 — Outside Lab?

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

### Element 21 — Diagnosis or Nature of Illness or Injury



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.

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

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

### Element 24A — Date(s) of Service

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

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS 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 DOS per line if:

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

### Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. Refer to Appendix 2 of this handbook for a list of POS codes.

### Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 2 of this handbook of this handbook for a list of TOS codes.

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

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

*Modifiers*

Enter the appropriate two-character modifier in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has *not* adopted all CPT, Healthcare Common Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System, or Medicare modifiers.

### Element 24E — Diagnosis Code

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 appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

### Element 24H — EPSDT/Family Planning

For Element 24H, enter the following:

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

When submitting claims for family planning services, all services should include either an "F" or a "B" in this element.

### Element 24I — EMG

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

### Element 24J — COB (not required)

### Element 24K — Reserved for Local Use (not required)

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

### Element 26 — Patient's Account No.

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 Report.

### Element 27 — Accept Assignment? (not required)

### Element 28 — Total Charge

Enter the total charges for this claim.

### Element 29 — Amount Paid (not required)

### Element 30 — Balance Due

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

### Element 31 — Signature of Physician or Supplier



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

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

### Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

### Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone #

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

# Appendix 9
# CMS 1500 Claim Form Sample for Family Planning Clinic Services

APPROVED OMB-0938-0008

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M ☐ F ☒

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

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

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

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

CITY: Anytown | STATE: WI

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

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX–XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

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

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

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

SIGNED



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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Attending Physician

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

1. V25.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 MM DD YY | | 3 | 9 | 99213 | | 1 | XX XX | 1.0 | F | | | |
| 2 MM DD YY | | 3 | 5 | 87210 | | 1 | XX XX | 1.0 | F | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

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

I.M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

# Appendix 10
# McKesson ClaimCheck®

## McKesson ClaimCheck® Monitors Medicaid Policy

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to Physicians' *Current Procedural Terminology* (CPT) codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/ integral or mutually exclusive.

ClaimCheck monitors the following Medicaid policy areas:

1. Unbundling (code splitting).
2. Incidental/integral procedures.
3. Mutually exclusive procedures.



## Unbundling (Code Splitting)

Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. ClaimCheck considers the single, most appropriate code for reimbursement when unbundling is detected.

If a provider bills certain procedure codes separately, ClaimCheck rebundles them into the single, most appropriate panel. For example, if the provider bills two procedure codes for layer closure of wounds, 12.6 cm to 20.0 cm and 20.1 cm to 30.0 cm (procedure codes 12035 and 12036), ClaimCheck rebundles them to layer closure of wounds over 30.0 cm (procedure code 12037).

ClaimCheck totals billed amounts for individual procedures. For example, if the provider bills three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. However, Wisconsin Medicaid reimburses the provider either the lesser of the billed amount or the maximum allowable fee for that procedure code.

## Incidental/Integral Procedures

Incidental procedures are those procedures performed at the same time as a more complex primary procedure. They require few additional physician resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery.

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a recipient undergoes a transurethral incision of the prostate (procedure code 52000), the cystourethroscopy is considered integral to the performance of the prostate procedure.

When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

## Mutually Exclusive Procedures

Mutually exclusive procedures are procedures that would not be performed on a single recipient during the same operative session or that use different codes to describe the same type of procedure.

For example, a vaginal hysterectomy (procedure code 58260) and a total abdominal hysterectomy (procedure code 58150) are mutually exclusive — either one or the other, but not both procedures, is performed.

When two or more procedures are mutually exclusive, Wisconsin Medicaid reimburses the procedure code with the highest provider-billed amount.

## Why was Payment for a Service Denied by ClaimCheck?

Providers should follow these procedures if they are uncertain about why particular services on a claim were denied:

1. Review the Explanation of Benefits denial code included on the Remittance and Status Report for the specific reason for the denial.

2. Review the claim submitted to ensure all information is accurate and complete.
3. Consult current CPT publications to make sure proper coding instructions were followed.
4. Consult this handbook section and other current Wisconsin Medicaid publications to make sure current policy and billing instructions were followed.
5. Contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 for further information or explanation.
6. If circumstances warrant an exception, submit an Adjustment Request Form with supporting documentation and the words "medical consultant review requested" written on the form.

## Appendix 11
## Breast Pump Order (for photocopying)

(A copy of the Breast Pump Order is located on the following page.)

**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1153 (Rev. 09/02)

## WISCONSIN MEDICAID
# BREAST PUMP ORDER

Wisconsin Medicaid requires 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 shall 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.

**INSTRUCTIONS:** The form is to be completed by the physician, given to the provider of the breast pump, and kept in the recipient's medical file as required under HFS 106.02(9), Wis. Admin. Code. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

| | 1. Date of Order |
|---|---|
| | |

| 2. Name — Recipient (Mother) | 3. Address — Recipient |
|---|---|
| | |
| 4. Date of Birth — Infant | 5. Recipient's Medicaid Identification Number |
| | |

**6. Clinical Guidelines**



All of the following must apply as a condition for Medicaid coverage. By checking the boxes, the physician verifies that all conditions are met.

- ❑ a. Physician ordered or recommended breast milk for infant.
- ❑ b. Potential exists for adequate milk production.
- ❑ c. Recipient plans to breast-feed long term.
- ❑ d. Recipient is capable of being trained to use the breast pump.
- ❑ e. Current or expected physical separation of mother and infant (e.g., illness, hospitalization, work) would make breast-feeding difficult or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

**7. Type of Pump**

Physician orders or recommends the following breast pump:

- ❑ a. Breast pump, manual, any type.
- ❑ b. Breast pump, electric (AC and/or DC), any type.
- ❑ c. Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies transformer, electric (AC and/or DC).

| 8. Name — Physician (Type or Print) | 9. Address — Physician |
|---|---|
| | |

| **10. SIGNATURE** — Physician | 11. Date Signed |
|---|---|
| | |

# Glossary of Common Terms

### Adjustment

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

### Allowed claim

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

### BadgerCare

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

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



### CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

### CPT

*Current Procedural Terminology.* A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

### Crossover claim

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

### DHCF

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

### DHFS

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

### DHHS

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

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

### DOS

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

### Dual entitlee

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

### ECS

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

### Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual.

### EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid provider of the status or action taken on a claim.

### EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).



### Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

### Fiscal agent

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

### HCPCS

Health Care Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as HCFA Common Procedure Coding System.

### HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

### ICD-9-CM

*International Classification of Diseases, Ninth Revision, Clinical Modification.* Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

### Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a given provider type and the maximum allowable fee and relative value units (RVUs) Wisconsin Medicaid assigns to each procedure code.

### Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

### Medically necessary

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

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
    1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
    2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;

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

### Payee

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



### POS

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

### QMB Only

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

### Qualifying circumstances

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

### R/S Report

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

### RVU

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

### TOS

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

# Index