

Independent Laboratory Services

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

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 Info. Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (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 Info. Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 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 Info. Claim Status Prior Authorization Status 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 Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (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 (ID) 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.

T Table of Contents

Preface	3
General Information	5
Provider Information	5
Independent Laboratory Certification Criteria	5
Clinical Certification for Laboratory Services	5
CLIA Enrollment	6
CLIA Regulations	6
Scope of CLIA	6
CLIA Certification Types	6
Provider Responsibilities	7
Recipient Information	7
Verifying Recipient Eligibility	7
Copayment	7
Coordination of Benefits	7
Health Insurance Coverage	7
Medicare Coverage	8
Qualified Medicare Beneficiary Only	8
Covered Services	9
Covered Laboratory Services	9
Laboratory Tests and Procedures	9
Laboratory Consultations	9
Multiple Laboratory Tests	9
Urinalysis	9
Laboratory Handling Fees	10
Laboratory Panels	10
Routine Venipuncture	10
Medicaid Abortion Policy	10
Coverage Policy	10
Services Incidental to a Noncovered Abortion	10
Noncovered Services	11
Preparing Claims	13
Claims Submission	13
Electronic Claims Submission	13
Paper Claims Submission	13
Where to Send Your Claims	13
Claims Submission Deadline	13
Claim Components	13
Diagnosis Codes	13
Procedure Codes	14

Complete Procedure vs. Professional and Technical Components	14
Unlisted Procedures	14
Modifiers	15
Billed Amounts	15
Reimbursement	15
McKesson ClaimCheck®	15
Claims Denied by ClaimCheck	16
Follow-Up to Claims Submission	16
Appendix	17
1. Wisconsin Medicaid-Allowable CLIA Waiver Certificate Procedure Codes	19
2. Wisconsin Medicaid-Allowable CLIA Provider-Performed Microscopy Procedure Codes	23
3. CLIA Specialty/Subspecialty Codes	25
4. Wisconsin Medicaid-Allowable Procedure Codes for Independent Laboratory Services	27
5. Wisconsin Medicaid-Allowable Place of Service and Type of Service Codes for Independent Laboratories	29
6. HCFA 1500 Claim Form — Completion Instructions	31
7. Sample HCFA 1500 Claim Form	39
Glossary	41
Index	45

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Preface

The Wisconsin Medicaid and BadgerCare Independent Laboratory Services Handbook is issued to independent laboratories 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 Wisconsin 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 2002, 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 Independent Laboratory Services Handbook consists of the following chapters:

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

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

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

Legal Framework of Wisconsin Medicaid and BadgerCare

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

Federal Law and Regulation

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

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.497 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.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

General Information

Physician office laboratories that accept 100 or more specimens during a calendar year on referral from other physicians are certified by Wisconsin Medicaid as independent laboratories, and they are covered by the policies described in this handbook.

The Independent Laboratory Services Handbook includes information for Medicaid-certified independent laboratories on provider eligibility, recipient eligibility, covered services, reimbursement methods, and billing instructions. Use this handbook in conjunction with the All-Provider Handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers.

The Independent Laboratory Services Handbook explains policies governing all Medicaid-certified independent laboratories that examine specimens from Medicaid recipients for health assessment or for the diagnosis, prevention, or treatment of any disease or health impairment.

Refer to the Laboratory and Radiology Services section of the Physician Services Handbook for Wisconsin Medicaid's policies that govern laboratory services provided by physician office laboratories.

Refer to the Medicaid Inpatient and Outpatient Hospital State Plans and to the Physician Services Handbook for Medicaid policies that govern laboratory services provided by hospital laboratories.

Provider Information

Independent Laboratory Certification Criteria

To become a Medicaid-certified independent laboratory service provider, Wisconsin Medicaid requires the laboratory to meet the following requirements:

- The laboratory must be independent of an attending or consulting physician's office and hospital. Wisconsin Medicaid may consider a laboratory as independent if the laboratory under a physician's direction is located outside a hospital.

- The laboratory must be Medicare certified.
- The laboratory must have a current, verified, unrevoked, and not suspended Clinical Laboratory Improvement Amendment (CLIA) certificate or CLIA waiver.
- The laboratory's services and office facilities must be available to other physicians for performing diagnostic tests.

A laboratory is not independent if it is either of the following:

- Located in a hospital and operated under a hospital's supervision.
- Operated under a hospital's organized medical staff and serves the hospital's patients.

Physician office laboratories that accept 100 or more specimens during a calendar year on referral from other physicians are certified by Wisconsin Medicaid as independent laboratories, and they are covered by the policies described in this handbook.

A laboratory that is not an independent laboratory may perform laboratory services for Wisconsin Medicaid under another Medicaid certification when the following two conditions are met:

1. The performing provider, such as the supervising physician, is a Medicaid-certified provider.
2. The laboratory provider has a current, verified, unrevoked, and not suspended CLIA certificate or CLIA waiver.

Clinical Certification for Laboratory Services

Congress implemented CLIA to improve the quality and safety of laboratory services. CLIA requires all laboratories and providers 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.

CLIA Regulations

Wisconsin Medicaid complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988.
- 42 CFR Part 493, Laboratory Requirements.

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.
- Test methods, equipment, instrumentation, reagents, materials, and supplies.
- Tests performed.

CLIA regulations apply to all Wisconsin Medicaid providers who perform

laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Clinics or groups with a single Medicaid billing number, but multiple CLIA numbers for different laboratories, may wish to contact Wisconsin Medicaid Provider Services to discuss various certification options.

The CMS issues five types of certificates for laboratories:

1. *Waiver certificate.* This certificate allows a laboratory to perform waived tests only. Refer to Appendix 1 of this handbook for a list of waived procedures, including those procedures that must be billed with a “QW” modifier.
2. *Provider-performed microscopy procedures certificate.* This certificate allows a physician, mid-level practitioner (i.e., nurse midwife, nurse practitioner, or physician assistant licensed by the State of Wisconsin), or dentist to perform microscopy and waived procedures only. Refer to Appendix 2 of this handbook for a list of Medicaid-allowable CLIA provider-performed microscopy procedures.
3. *Registration certificate.* This certificate allows a laboratory to conduct moderate or high complexity tests until the laboratory is determined to be in compliance through a CMS survey performed by the Wisconsin State Agency for CLIA.

Clinics or groups with a single Medicaid billing number, but multiple CLIA numbers for different laboratories, may wish to contact Wisconsin Medicaid Provider Services to discuss various certification options.



Providers must immediately notify the Clinical Laboratory Unit of changes in certificate types

4. *Compliance certificate.* This certificate is issued to a laboratory (for moderate and/or high complexity tests) after a CMS inspection performed by the State Agency finds the laboratory in compliance with all applicable complexity-level requirements.
5. *Accreditation certificate.* This certificate is issued on the basis of the laboratory's accreditation by a CMS-approved accreditation organization. The six major approved accreditation organizations are:
 - American Association of Blood Banks (AABB).
 - American Osteopathic Association (AOA).
 - American Society for Histocompatibility and Immunogenetics (ASHI).
 - COLA.
 - College of American Pathologists (CAP).
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Use the HCFA-116 CLIA application to obtain program certificates. You may obtain HCFA-116 forms from the following address:

Clinical Laboratory Unit
Bureau of Quality Assurance
Division of Supportive Living
PO Box 2969
Madison WI 53701-2969

Providers must notify the Clinical Laboratory Unit in writing within 30 days of any change(s) in ownership, name, location, or director.

Providers must immediately notify the Clinical Laboratory Unit of changes in certificate types. When a specialty or subspecialty is added or deleted, providers must notify the Clinical Laboratory Unit within six months. Providers may contact the Clinical Laboratory Unit at (608) 266-5753.

Provider Responsibilities

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for information about the

responsibilities of Medicaid-certified providers, including all of the following:

- Fair treatment of recipients.
- Maintenance of records.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.
- Grounds for provider sanctions.
- Additional state and federal requirements.

Recipient Information

Verifying Recipient Eligibility

Wisconsin Medicaid providers should verify recipient eligibility and identify any limitations to the recipient's coverage *before* providing services. Refer to the All-Provider Handbook for detailed information on accessing the Eligibility Verification System and eligibility for Wisconsin Medicaid. For telephone numbers regarding recipient eligibility, refer to the page of Important Telephone Numbers at the beginning of this handbook.

Copayment

Wisconsin Medicaid does not require a recipient copayment for independent laboratory services.

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 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.
- 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 entitlements. Claims for Medicare-covered services provided to dual entitlements must be billed to Medicare prior to Wisconsin Medicaid.

Independent laboratories not certified by Medicare may be retroactively certified by Medicare for the date a service was provided. Contact the appropriate Medicare fiscal intermediary for certification information.

Providers are required to accept assignment on Medicare claims for dual entitlements. The dual

entitlement is not liable for Medicare's coinsurance or deductible.

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

If the service provided to a dual entitlement is covered by Medicare (in at least some situations), but *Medicare denied* the service on a correctly completed claim, submit a new claim for the denied service to Wisconsin Medicaid and indicate the appropriate Medicare disclaimer code in Element 11 of the HCFA-1500 claim form. Refer to Appendix 6 (Element 11) of this handbook for a list of the Medicare disclaimer codes.

Qualified Medicare Beneficiary Only

Qualified Medicare Beneficiary-Only (QMB-Only) recipients are eligible *only* for Wisconsin Medicaid payment of the coinsurance and deductible for Medicare-allowed services.

Wisconsin Medicaid does not reimburse claims for QMB-Only recipients that Medicare does not allow. Independent laboratories are required to accept assignment on Medicare claims for QMB-Only recipients.

Claims for Medicare-covered services provided to dual entitlements must be billed to Medicare prior to Wisconsin Medicaid.

Covered Services

Covered Laboratory Services

As specified in HFS 107.25(1), Wis. Admin. Code, Wisconsin Medicaid covers professional and technical diagnostic services only if the laboratory services meet one of the following conditions:

- The services are performed by or under the supervision of a physician.
- The services are prescribed by a physician and are provided by a Clinical Laboratory Improvement Amendment (CLIA)-certified laboratory.

Laboratory Tests and Procedures

Laboratories may only perform tests and procedures that are authorized in the laboratory site's CLIA certificate. Appendix 3 of this handbook specifies the CLIA specialties/subspecialties.

Laboratory Consultations

Independent laboratories may be reimbursed for laboratory consultations only when the consultation is medically necessary and appropriate for the recipient's treatment. Consultation procedure codes are listed with type of service (TOS) "3" in Appendices 1, 2, and 4 of this handbook. Laboratory consultations are reimbursable only when performed at the request of the attending physician and when the results are contained in a written report that becomes part of the recipient's medical record.

Multiple Laboratory Tests

Claims for multiple laboratory tests must be submitted using a panel or aggregate procedure code (e.g., hemogram) when such a

Current Procedural Terminology (CPT) code exists. This policy is monitored by Wisconsin Medicaid's claim review system, McKesson ClaimCheck®. Refer to the Preparing Claims chapter of this handbook for more information.

Total reimbursement for multiple chemistry or other laboratory tests submitted individually may not exceed the reimbursement rate established by Wisconsin Medicaid for the most closely related panel or aggregate code, as determined by the Division of Health Care Financing (DHCF). The provider's reimbursement may be corrected on a post-payment basis by Wisconsin Medicaid.

For example, an electrolyte panel (80051) must include the following tests:

- Carbon dioxide (82374).
- Chloride (82435).
- Potassium (84132).
- Sodium (84295).

If a provider performs fewer than all four tests in the panel, each code must be billed individually to Wisconsin Medicaid and each will be reimbursed as a separate procedure. However, Wisconsin Medicaid may later reconsider the reimbursement and adjust it to equal the reimbursement rate for the panel.

Urinalysis

When two or more services listed in the urinalysis section of CPT are performed on the same day for the same recipient by the same provider at an independent laboratory, place of service "A," they are reimbursed collectively at no more than the maximum fee amount for procedure code 81000 (Urinalysis, by dip stick or tablet reagent ... non-automated, with microscopy).

Laboratories may only perform tests and procedures that are authorized in the laboratory site's CLIA certificate.

Laboratory Handling Fees

Wisconsin Medicaid reimburses the laboratory provider who performed the clinical diagnostic laboratory test and reimburses the provider who collected the specimen for the handling fee.

Wisconsin Medicaid reimburses an independent laboratory a handling fee when the laboratory sends specimens to an outside laboratory for analysis or interpretation. The handling fee covers the collection, preparation, forwarding, and handling of obtained specimens. One handling fee is reimbursed per provider, per recipient, per date of service, regardless of the number of specimens sent.

Procedure code 99001 (TOS “5”) is used when submitting a claim for forwarding a specimen from an independent laboratory to another laboratory. It is not necessary to indicate the specific laboratory test performed.

A handling fee is not reimbursable if the independent laboratory is reimbursed for the professional and/or technical component of the laboratory test.

Laboratory Panels

Wisconsin Medicaid uses the most current CPT procedure code definitions. All of the panel codes and individual laboratory codes are specified in the CPT. Wisconsin Medicaid assigns individual laboratory codes into panels according to the CPT definitions and monitors billing of procedure codes through ClaimCheck.

Routine Venipuncture

Routine venipuncture is not separately reimbursable, but is included in the

reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Providers may not bill recipients for routine venipuncture.

Medicaid Abortion Policy

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 that the abortion meets this condition by signing a certification.
- 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 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, the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.

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

Services Incidental to a Noncovered Abortion

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

Noncovered Services

Wisconsin Medicaid does not reimburse independent laboratories for laboratory services that are not medically necessary. This includes, but is not limited to, the following services:

- Services to enhance the prospects of fertility.
- Services that are experimental in nature.
- Services that do not have Food and Drug Administration or DHCF approval.
- Court-ordered services without a referring physician.

As specified in HFS 107.25, Wis. Admin. Code, Wisconsin Medicaid does not cover laboratory tests performed outside a laboratory's certified areas.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Preparing Claims

Claims Submission

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

Electronic Claims Submission

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

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

Wisconsin Medicaid provides software for submitting claims electronically. For more information on 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 software and have technical questions, please contact Wisconsin Medicaid's customer service at (800) 822-8050.

Paper Claims Submission

Providers submitting paper claims must use the HCFA 1500 claim form (dated 12/90). Refer to Appendices 6 and 7 of this handbook for HCFA 1500 claim form completion instructions and a completed sample.

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

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

Where to Send Your Claims

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

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

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days of 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, requirements for submission to Late Billing Appeals, and adjustment information 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/.

Claim Components

Diagnosis Codes

Independent laboratories may use the general diagnosis code V72.6 for laboratory exams or the appropriate diagnosis code from the most current *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) for each symptom or condition related to the services provided. Code V72.6 may apply to most independent laboratory procedures, with the exception of services provided to presumptively eligible pregnant women. These claims must include a pregnancy-related diagnosis code.

Wisconsin Medicaid denies claims received without the appropriate ICD-9-CM diagnosis code or without the general diagnosis code V72.6 for laboratory exams.

Independent laboratories may use the general diagnosis code V72.6 for laboratory exams or the appropriate diagnosis code from the most current *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) for each symptom or condition related to the services provided.

Procedure Codes

Wisconsin Medicaid requires that all HCFA 1500 claim forms have either a HCFA Common Procedure Coding System (HCPCS) code, a current *Current Procedural Terminology* (CPT) code, or a local Medicaid code that best describes the procedure performed. Wisconsin Medicaid denies claims or adjustments without the appropriate code.

Wisconsin Medicaid does not allow reimbursement for all CPT codes (e.g., fertility-related services are not covered). In addition, the procedure code billed must be appropriate for the Clinical Laboratory Improvement Amendment (CLIA) certification type indicated in the billing provider's Medicaid file.

Refer to Appendix 4 of this handbook for allowable procedures and Appendix 5 of this handbook for type of service (TOS) and place of service codes for independent laboratory services.

Complete Procedure vs. Professional and Technical Components

Most laboratory services are performed and reimbursed as a complete procedure (TOS "5").

A relatively small number of laboratory procedure codes have technical (TOS "U") and professional (TOS "X") components. Nevertheless, these procedures are billed as a complete procedure (TOS "5") when both the technical and professional components are billed by a single laboratory. A *written report* must be produced and maintained in the recipient's medical record when one of these procedure codes (having technical and professional components) is billed with either a TOS "X" or "5."

At times the technical component is performed by a physician clinic but the professional component is performed by an independent laboratory. In this situation, each provider bills

and is reimbursed only for the service performed, as follows:

- The provider performing the technical component bills only the technical component (TOS "U").
- The independent laboratory performing the professional component bills 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-patient encounter (i.e., the evaluation and management service).

Unlisted Procedures

Claims submitted for an unlisted (nonspecific) procedure code (e.g., procedure code 81099) require documentation describing the procedure performed. The documentation must be sufficient to allow the Division of Health Care Financing chief medical officer to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in HFS 101.03(96m), Wis. Admin. Code.

If the procedure can be described and its medical necessity explained in a few words, providers may use Element 19 ("Reserved for Local Use") of the HCFA 1500 claim form. If there is insufficient space, write "see attached" in Element 19 and attach additional documentation to the claim.

New laboratory tests that have not received a CPT or HCPCS procedure code number should be billed as an unlisted procedure. Wisconsin Medicaid reimburses only tests that are approved by the federal Food and Drug Administration.

A *written report* must be produced and maintained in the recipient's medical record when one of these procedure codes (having technical and professional components) is billed with either a TOS "X" or "5."



Providers are required to bill their usual and customary charge for the service performed.

Modifiers

Wisconsin Medicaid accepts only the “QW” modifier for CLIA-waived procedures. Providers should use TOS “X” or “U” rather than modifier “26” or “TC” for professional or technical components. Refer to Appendix 1 of this handbook for a complete list of CLIA-waiver certificate procedure codes.

Billed Amounts

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

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

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge and the maximum allowable fee established by the Department of Health and Family Services.

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code.

To obtain a maximum allowable fee schedule for independent laboratory services, providers may:

- 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 using the order form located in the Claims Submission section of the All-Provider Handbook or by writing to:

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

McKesson ClaimCheck[®]

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.

ClaimCheck monitors the following Medicaid policy areas:

1. *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.

For example, if a provider submits separate claims for certain laboratory tests performed on the same recipient on the same date of service, ClaimCheck rebundles them into the single, most

appropriate panel (e.g., 80055 — obstetric panel, or 80076 — hepatic function panel).

ClaimCheck totals billed amounts for individual procedures. For example, if you bill 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.

2. *Incidental/integral procedures.*

Incidental/integral procedures are those procedures performed as part of or 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.

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

3. *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.

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

Claims Denied by ClaimCheck

Follow these procedures if you 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 (R/S) 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 and other Wisconsin Medicaid publications to make sure current policy and claims submission instructions were followed.
5. Contact Wisconsin Medicaid's Provider Services at (608) 221-4746 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.

Follow-Up to Claims Submission

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the R/S Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim, so that Wisconsin Medicaid receives the claim for processing within 365 days of the date of the original service.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for detailed information about the following:

- Adjustments to paid claims.
- Denied claims.
- Duplicate payments.
- Return of overpayments.
- The R/S Report.

Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim, so that Wisconsin Medicaid receives the claim for processing within 365 days of the date of the original service.

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 1

Wisconsin Medicaid-Allowable CLIA Waiver Certificate Procedure Codes

The Wisconsin Medicaid-allowable Clinical Laboratory Improvement Amendment (CLIA) waiver certificate procedure codes may change due to CLIA or *Current Procedural Terminology* code changes. Refer to the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, Web site at www.cms.hhs.gov/clia/ for more information.

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
80061	QW	Lipid panel	Cholestech
80101	QW	Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class	Dynagen, Inc.; Pharmatech; Worldwide Medical Corp.
81002		Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	various
81003	QW	automated, without microscopy	Bayer Corp.; Boehringer Mannheim Corp.; Roche Diagnostics/Boehringer Mannheim Corp.; Teco Diagnostics
81007	QW	Urinalysis; bacteriuria screen, except by culture or dipstick	Savyon/USA
81025		Urine pregnancy test, by visual color comparison methods	various
82010	QW	Acetone or other ketone bodies, serum; quantitative	Abbott Laboratories, Inc.; Polymer Technology Systems, Inc.
82044	QW	Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)	Bayer Corp.; Boehringer Mannheim Corp.; Roche Diagnostics Corp.
82055	QW	Alcohol (ethanol); any specimen except breath	STC Technologies, Inc.; OraSure Technologies, Inc.
82120	QW	Amines, vaginal fluid, qualitative	Litmus Concepts, Inc.
82270		Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, 1-3 simultaneous determinations	various
82273	QW	other sources	SmithKline Diagnostics, Inc.
82465	QW	Cholesterol, serum or whole blood, total	ActiMed Laboratories, Inc.; Boehringer Mannheim Corp; Chemtrak; Cholestech; Johnson & Johnson; Lifestream Technologies; Polymer Technology Systems, Inc.
82570	QW	Creatinine; other source	Bayer Corp.
82679	QW	Estrone	Unipath Limited

**Appendix 1
(Continued)**

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
82947	QW	Glucose; quantitative, blood (except reagent strip)	Cholestech; HemoCue
82950	QW	post glucose dose (includes glucose)	Cholestech; HemoCue
82951	QW	tolerance test (GTT), three specimens (includes glucose)	Cholestech; HemoCue
82952	QW	tolerance test, each additional beyond three specimens	Cholestech; HemoCue
82962		Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use	Abbott Laboratories, Inc.; LXN Corporation; various
82985	QW	Glycated protein	LXN Corporation
83001	QW	Gonadotropin; follicle stimulating hormone (FSH)	Genua 1994, Inc.
83002	QW	luteinizing hormone (LH)	Unipath Limited
83026		Hemoglobin; by copper sulfate method, non-automated	various
83036	QW	Hemoglobin; glycated	Bayer Corp.; Metrika, Inc.
83518	QW	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip)	Bion Diagnostic Sciences, Inc.
83718	QW	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	Cholestech; Polymer Technology Systems, Inc.
83986	QW	pH, body fluid, except blood	Various; Litmus Concepts, Inc.
84460	QW	Transferase; alinine amino (ALT) (SGPT)	Cholestech Corp.
84478	QW	Triglycerides	Cholestech; Polymer Technology Systems, Inc.
84703	QW	Gonadotropin, chorionic (hCG); qualitative	Bayer Corp.
84830		Ovulation tests, by visual color comparison methods for human luteinizing hormone	various
85013		Blood count; spun microhematocrit	various
85014	QW	other than spun hematocrit	Wampole Laboratories
85018	QW	hemoglobin	GDS Technology, Inc.; HemoCue

**Appendix 1
(Continued)**

Procedure Code	Modifier	Procedure Description	CLIA-Allowable Manufacturer of Tests for Waived Procedures
85610	QW	Prothrombin time	Avocet Medical, Inc.; Boehringer Mannheim Corp.; International Technidyne Corp.; Roche Diagnostics Corp.; Roche Diagnostics/Boehringer Mannheim Corp.
85651		Sedimentation rate, erythrocyte; non-automated	various
86308	QW	Heterophile antibodies; screening	Applied Biotech, Inc.; Genzyme Diagnostics; Princeton BioMeditech Corp.; Quidel Corporation; Wampole Laboratories; Wyntek Diagnostics, Inc.
86318	QW	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)	Abbott Laboratories; Applied Biotech, Inc.; Cortecs Diagnostics Limited; Princeton BioMeditech; Quidel Corp.; Remel; SmithKline Diagnostics, Inc.; Trinity BioTech
87077	QW	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate	Ballard Medical Products; Delta West Tri-Med Specialties; Mycoscience Labs, Inc.; Serim
87449	QW	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	Zymetx, Inc.
87880	QW	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A	Applied Biotech, Inc.; Binax; Genzyme Diagnostics; Princeton BioMeditech; Quidel Corp.; Wyntek Diagnostics, Inc.
87899	QW	not otherwise specified	Quidel Corp.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 2

Wisconsin Medicaid-Allowable CLIA Provider-Performed Microscopy Procedure Codes

The Wisconsin Medicaid-allowable Clinical Laboratory Improvement Amendment provider-performed microscopy procedure codes may change. Refer to the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, Web site at www.cms.hhs.gov/clia for more information.

CPT Codes	
Procedure Code	Procedure Description
81000	Urinalysis; by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	automated, with microscopy
81015	Urinalysis; microscopic only
81020	two or three glass test
89190	Nasal smear for eosinophils

ARCHIVAL USE ONLY

HCPCS Codes	
Procedure Code	Procedure Description
G0026	Fecal leucocyte examination
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens
Q0112	All potassium hydroxide (koh) preparations
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 3

CLIA Specialty/Subspecialty Codes

The Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, certifies laboratories by specialty/subspecialty categories based on the complexity of the tests performed. The table below indicates the specialty/subspecialty categories.

Specialties and Subspecialties Codes and Descriptions	
010	Histocompatibility
100	Microbiology
110	Bacteriology
115	Mycobacteriology
120	Mycology
130	Parasitology
140	Virology
150	Other
200	Diagnostic Immunology
210	Syphilis serology
220	General immunology
300	Chemistry
310	Routine
320	Urinalysis
330	Endocrinology
340	Toxicology
350	Other
400	Hematology
500	Immunohematology
510	ABO group and Rh type
520	Antibody detection-transfusion
530	Antibody detection-nontransfusion
540	Antibody identification
550	Compatibility testing
560	Other
600	Pathology
610	Histopathology
620	Oral pathology
630	Cytology
800	Radio Bioassay
900	Clinical Cytogenetics

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 4

Wisconsin Medicaid-Allowable Procedure Codes for Independent Laboratory Services

Pathology and Laboratory Services		
Service	Procedure Codes	Type of Service
Organ or Disease Oriented Panels	80048-80090	5
Drug Testing	80100-80103	5
Therapeutic Drug Assays	80150-80299	5
Evocative/ Suppression Testing	80400-80440	5
Consultations	80500-80502	3
Urinalysis	81000-81099	5
Chemistry	82000-83018	5
	83020-83021	5, U, X
	83026-83690	5
	83715-83716	5, U, X
	83718-83785	5
	83788-83789	5, U, X
	83805-83906	5
	83912	5, X
	83915-84160	5
	84165- 84182	5, U, X
Hematology and Coagulation	84202-84999	5
	85002-85385	5
	85390	5, U, X
	85400-85557	5
	85576	5, U, X
Immunology	85585-85999	5
	86000-86243	5
	86255-86256	5, U, X
	86277-86318	5
	86320-86334	5, U, X
Transfusion Medicine	86336-86849	5
	86850-86999	5

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Pathology and Laboratory Services (continued)		
Service	Procedure Codes	Type of Service
Microbiology	87001-87158	5
	87164-87166	5, U, X
	87168-87206	5
	87207	5, U, X
	87210-87904	5
	87999	5, U, X
Cytopathology	88104-88125	5, U, X
	88130-88140	5
	88141	X
	88142-88155	5
	88160-88162	5, U, X
	88164-88167	5
	88172-88199	5, U, X
Cytogenetic Studies	88230-88289	5
	88291	X
	88299	5, U, X
Surgical Pathology	88300-88319	5, U, X
	88321-88329	3
	88331-88399	5, U, X
Transcutaneous Procedures	88400	5
Other Procedures	89050-89261	5
	89264	5, U, X
	89300-89321, 89350, 89360-89365	5
	89399	5, U, X
Special Services, Procedures and Reports	99000-99001	5
HCFA Common Procedure Coding System Codes	G0026-G0027	5
	P2028-P3001, P9010-P9044, P9615	5
	Q0111-Q0114	5
	S3645-S3650	5
	S3708	5, U, X

Appendix 5

Wisconsin Medicaid-Allowable Place of Service and Type of Service Codes for Independent Laboratories

Place of Service Code	
Code	Description
A	Independent laboratory

Type of Service Codes	
Code	Description
3	Consultations
5	Diagnostic Laboratory (Total Charge) HealthCheck Laboratory
U	Diagnostic Laboratory (Medical/Technical)/Ultrasound
X	Diagnostic Laboratory (Professional)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 6

HCFA 1500 Claim Form Completion Instructions

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

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

Element 1 — Program Block/Claim Sort Indicator

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

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid 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, Patient's Sex

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

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's Medicaid identification number, enter the following:

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

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

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

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

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

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

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

- When the recipient has dental ("DEN") insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, and the service

Appendix 6 (Continued)

requires third-party billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes must be indicated in the first box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code Description

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

OI-D DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the health insurer.

OI-Y YES, the recipient has health insurance, but it was not billed for reasons including, but not limited to:

- ✓ The recipient denied coverage or will not cooperate.
- ✓ The provider knows the service in question is not covered by the carrier.
- ✓ The recipient's health insurance failed to respond to initial and follow-up claims.
- ✓ Benefits are not assignable or cannot get assignment.

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

Code Description

OI-P PAID by HMO. The amount paid is indicated on the claim.

OI-H HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

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

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

Element 11 — Insured's Policy, Group, or FECA Number

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

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

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The non-physician provider's Wisconsin Medicaid file shows he or she is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

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

Appendix 6 (Continued)

The following Medicare disclaimer codes can be used when appropriate:

Code Description

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

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

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

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

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

For *Medicare Part A* (all three criteria must be met):

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

Appendix 6 (Continued)

For *Medicare Part B* (all three criteria must be met):

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

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

For *Medicare Part A* (all three criteria must be met):

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

For *Medicare Part B* (all three criteria must be met):

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

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

For *Medicare Part A* (all three criteria must be met):

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

For *Medicare Part B* (all three criteria must be met):

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

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)

Appendix 6 (Continued)

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

Required for non-emergency services. Enter the referring physician's six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the 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, the provider must describe the procedure. If Element 19 does not provide enough space for the procedure description, or if the provider bills multiple unlisted procedure codes, the provider must attach documentation to the claim describing the procedure(s). In this instance, the provider should 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 general code V72.6 for laboratory exams or the current *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. Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

This field must be left blank. Do *not* enter a Clinical Laboratory Improvement Amendment (CLIA) number in this field.

Element 24A — Date(s) of Service

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

- When billing for one 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.

Appendix 6 (Continued)

- 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 5 of this handbook for a list of allowable POS codes for independent laboratories.

Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 5 of this handbook for a list of allowable TOS codes for independent laboratories.

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, 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

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

Appendix 6 (Continued)

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

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

Element 30 — Balance Due

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

Element 31 — Signature of Physician or Supplier

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

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

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

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

Enter the provider’s name (exactly as indicated on the Wisconsin Medicaid 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.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 7

Sample HCFA 1500 Claim Form

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										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 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 609 Willow					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)	
CITY Anytown			STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY	
ZIP CODE 55555			TELEPHONE (Include Area Code) (XXX) XXX-XXXX		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OIP					10d. RESERVED FOR LOCAL USE					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 _____	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring Physician					17a. I.D. NUMBER OF REFERRING PHYSICIAN 11223344					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V72.6					23. PRIOR AUTHORIZATION NUMBER					29. AMOUNT PAID \$ XX XX	
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY					25. FEDERAL TAX I.D. NUMBER SSN EIN					30. BALANCE DUE \$ XX XX	
26. PATIENT'S ACCOUNT NO. 1234JED					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 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 #					PIN# _____ GRP# _____	

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

PLEASE PRINT OR TYPE

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

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

I.M. Authorized

MM/DD/YY

87654321

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

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), formerly HCFA, 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.

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 (DHFS) 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.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

HCPCS

HCFA Common 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.

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.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Index

- Abortion, 10
 - Coverage policy, 10
 - Services incidental to a noncovered abortion, 10
- Billed amounts, 15
- Certification, 5
- Claim components, 13
 - Billed amounts, 15
 - Complete procedure vs. professional and technical components, 14
 - Diagnosis codes, 13
 - Modifiers, 15
 - Procedure codes, 14
 - Reimbursement, 15
 - Unlisted procedures, 14
- Claims, preparing, 13
 - Billed amounts, 15
 - Electronic, 13
 - Follow-up, 16
 - HCFA 1500, *see* HCFA 1500 claim form
 - McKesson Claim Check®, 15
 - Paper, 13
 - Procedure codes, 14
 - Reimbursement, 15
 - Submission, 13
 - Submission deadline, 13
 - Where to send, 13
- Clinical Laboratory Improvement Act (CLIA), 5
 - Certification types, 6
 - Enrollment, 6
 - Regulations, 6
 - Scope, 6
- Complete procedure vs. professional and technical components, 14
- Consultations, 9
- Coordination of Benefits, 7
 - Health insurance coverage, 7
 - Medicare coverage, 8
- Qualified Medicare Beneficiary (QMB) Only, 8
- Copayment, 7
- Covered services, 9
 - Tests and procedures, 9
 - Laboratory consultations, 9
 - Multiple laboratory tests, 9
 - Urinalysis, 9
 - Handling fees, 10
 - Panels, 10
 - Routine venipuncture, 10
- Diagnosis codes, 13
- Electronic claims, 13
- Follow-up to claims submission, 16
- Handling fees, 10
- HCFA 1500 claim form
 - Completed sample, 39
 - How to obtain, 13
 - Instructions, 31
- HMO, private, *see* Insurance, commercial
- Insurance, commercial, 7
- Laboratory services, 9
 - Consultations, 9
 - Laboratory handling fees, 10
 - Laboratory panels, 10
 - Laboratory tests and procedures, 9
 - Laboratory consultations, 9
 - Multiple laboratory tests, 9
 - Urinalysis, 9
 - Routine venipuncture, 10
- McKesson ClaimCheck®, 15
- Maximum fee schedule, 15
- Medicare coverage, 8

Modifiers, 15
 Multiple laboratory tests, 9
 Noncovered services, 11
 Panels, 10
 Paper claims submission, 13
 Place of service codes, 29
 Procedure codes, 14
 CLIA waiver certificate procedure codes, 19
 CLIA provider-performed microscopy procedure codes, 23
 Wisconsin Medicaid-allowable procedure codes for laboratory services, 27
 Provider information, 5
 Certification criteria, 5
 CLIA certification, 5
 Responsibilities, 7
 Qualified Medicare Beneficiary Only, 8
 Recipient information, 7
 Copayment, 7
 Coordination of benefits, 7
 Health insurance coverage, 7
 Medicare coverage, 8
 Qualified Medicare Beneficiary Only, 8
 Verifying eligibility, 7
 Reimbursement, 15
 Routine venipuncture, 10
 Submission deadline for claims, 13
 Tests and procedures, 9
 Type of service codes, 29
 Unlisted procedures, 14
 Urinalysis, 9
 Where to send your claims, 13
 Qualified Medicare Beneficiary Only, 8

ARCHIVAL USE ONLY
 Refer to the Online Handbook
 for current policy