Hospital Services

inpatient services

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

Important Telephone 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 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 Information 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 Information 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. - 5:30 p.m. (M-F)

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*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 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.

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Preface

The Wisconsin Medicaid and BadgerCare Hospital Services Handbook is issued to hospital providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. 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 section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Hospital Services Handbook consists of the following sections:

- Inpatient Services.
- Outpatient Services.

In addition to the Hospital 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.

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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.

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Provider Information

The Inpatient Services section of the Hospital Services Handbook includes information for inpatient stays at acute care general hospitals and institutions for mental disease (IMD), such as covered services, reimbursement methodology, and claims submission information that applies to fee-for-service Medicaid providers.

Provider Eligibility and Certification

Wisconsin Medicaid certifies hospitals as either acute care general hospitals or IMDs and bases the hospital certification on the hospital's eligibility for certification with Medicare or with the Joint Commission on Accreditation of Healthcare Organizations.

Wisconsin Medicaid certifies acute care general hospitals and IMDs according to HFS 105.07 and 105.21, Wis. Admin. Code, respectively. A facility determined by the Wisconsin Department of Health and Family Services to be an IMD may *not* be certified as an acute care general hospital under this section.

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Medicare certification does *not* automatically certify a hospital with Wisconsin Medicaid.

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Medicare certification does *not* automatically certify a hospital with Wisconsin Medicaid.

The Wisconsin Medicaid hospital certification packet contains detailed requirements for certification. Providers are required to meet these requirements and report necessary changes to Wisconsin Medicaid. For more information on becoming certified, or to obtain a certification packet, contact Provider Services at (800) 947-9627 or (608) 221-9883 or visit the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Professional and Other Services Needing Separate Certification

Certain providers who provide professional and other services within an inpatient hospital require separate Medicaid certification for the providers. These include the following:

- Air, water, and land ambulance providers.
- Anesthesiologist assistants.
- Audiologists.
- Certified registered nurse anesthetists.
- Chiropractors.
- Dentists.
- Durable medical equipment and disposable medical supplies suppliers for nonhospital use.
- Hearing aid providers.
- Nurse midwives.
- Nurse practitioners.
- Optometrists.
- Pharmacies (for take-home drugs on the date of discharge).
- Physician assistants.
- Physicians.
- Podiatrists.
- Psychiatrists.
- Psychologists.
- Specialized medical vehicle providers.

For more information on Medicaid provider certification, refer to the All-Provider Handbook.

Approved Hospital Facility

Only Medicaid-covered services provided by a certified hospital facility are eligible for payment under Wisconsin Medicaid's inpatient hospital payment formula. Wisconsin Medicaid defines "hospital facility" as the physical entity, surveyed and approved by the Division of Supportive Living, Bureau of Quality Assurance (BQA) under ch. 50, Wis. Stats. The BQA facility approval survey covers the building that the hospital identifies as constituting its operation.

This building must meet strict fire and life safety codes and administrative and program standards specifically required by the BQA for hospitals. Wisconsin Medicaid considers the unique costs of hospital functions, including safety code compliance, in the determination of hospital inpatient services reimbursement rates.

CLIA Certification

Congress implemented the Clinical Laboratory Improvement Act (CLIA) to improve the quality and safety of laboratory services. CLIA establishes standards and enforcement procedures.

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.

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

- Public Health Service CLIA of 1988.
- 42 CFR Part 493.

CLIA governs all laboratory operations, including the following:

- Accreditation.
- Certification.
- Equipment.
- Facility standards.
- Fees.
- Instrumentation.
- Materials.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Reagents.
- Records and information systems.
- Sanctions.
- Supplies.
- Test methods.
- Tests performed.

Claims for laboratory tests performed by hospital providers without valid CLIA certification, including an identification number, are subject to Medicaid recovery.

To obtain a CLIA certification application, write to the following address or call:

Clinical Laboratory Unit
Bureau of Quality Assurance
Division of Supportive Living
PO Box 2969
Madison WI 53701-2969
(608) 266-5753

Provider Responsibilities

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for specific responsibilities as a Medicaid-certified provider. This section includes detailed information concerning, but not limited to, the following:

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

Verifying Recipient Eligibility

Wisconsin Medicaid hospital 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 (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for information about these methods of verifying eligibility. Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on how to use the methods of verifying eligibility.

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.

Special Benefit Categories

Some Medicaid recipients covered under special benefits categories have limited coverage. Medical status codes received through the EVS identify recipients with limited benefits. Providers may refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on the different special benefits categories.

Medicaid Managed Care Coverage

The information in this handbook applies to fee-for-service recipients who receive hospital services. Medicaid HMOs may have different policies regarding hospital services. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

Copayments and Billed Amounts

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Except for the copayment exemptions noted in the All-Provider Handbook, all recipients are responsible for paying part of the costs involved in obtaining hospital services. The copayment for inpatient hospital services is $3.00 per day (up to $75.00 per stay).

Wisconsin Medicaid does not reimburse for infant claims submitted under the mother's identification number beyond the first 10 days of the infant's life.

For more information on copayment and copayment exemptions, refer to the All-Provider Handbook.

Collection of Copayment

Providers who perform services that require recipient copayment are required to make a reasonable attempt to collect that copayment from the recipient. The provider may not waive the recipient copayment requirement unless the provider determines that the cost of collecting the payment, coinsurance, or deductible exceeds the amount to be collected. Providers may not deny services to a recipient for failing to make a copayment.

Recipient Freedom from Liability for Covered Services

Providers may not charge a recipient for covered services and items furnished under Wisconsin Medicaid except for Wisconsin Medicaid recipient copayments, if applicable. At the same time, providers may not deny services to recipients who do not make copayments.

A provider may not charge a recipient for covered services if the provider fails to:

- Comply with Wisconsin Medicaid policy and is denied Medicaid reimbursement.
- Meet Wisconsin Medicaid program requirements.
- Seek or obtain necessary prior authorization to perform the services and is denied Medicaid reimbursement.

Newborn Reporting

Wisconsin Medicaid does not reimburse for infant claims submitted under the mother's identification number beyond the first 10 days of the infant's life.

Hospitals are required to promptly report newborns born to fee-for-service Medicaid recipients to Wisconsin Medicaid. Establishing a newborn's Medicaid eligibility results in better health outcomes and fewer delays in provider reimbursement.

Hospitals may report newborns born to Medicaid recipients by submitting a Wisconsin Medicaid Newborn Report, or another form developed by the hospital that contains all the same information, to Wisconsin Medicaid. Refer to Appendix 11 of this section for a sample Wisconsin Medicaid Newborn Report form.

Hospitals have the option of sending newborn reports in a summary format on a weekly basis to Wisconsin Medicaid or as individual reports for each newborn. However, the summary report must contain all the information provided in the Newborn Report form.

Provider Information

If possible, the Newborn Report should be submitted to Wisconsin Medicaid with the child's given name (first and last name), rather than "baby boy" or "baby girl" as the first name. The four-digit year should be included when reporting the child's date of birth. (To report a child's date of death, the two- or four-digit year format may be used). Wisconsin Medicaid still requires hospitals to submit the newborn report in instances in which the baby is born alive, but does not survive.

Submit the Newborn Report to Wisconsin Medicaid by mail or fax to the following address or fax number:

Newborn Reporting
PO Box 6470
Madison WI 53716
Fax: (608) 224-6318

This information on newborn reporting pertains to the birth of a newborn to a Medicaid recipient who is not enrolled in an HMO.

Under the Medicaid managed care contract, HMOs are required to report to Wisconsin Medicaid the birth of a newborn to a mother enrolled in an HMO. Because of this requirement, hospitals and HMOs should coordinate the newborn reporting function to prevent duplicate reporting by the hospital and HMO of the same newborn. Following these procedures assures more timely reimbursement for services provided to infants.

Once the completed Newborn Report is submitted to Wisconsin Medicaid, the following procedures take place:

- A pseudo (temporary) Medicaid identification number is assigned to the newborn, regardless of whether the newborn is named (if Medicaid eligibility is not yet on file).
- A Medicaid Forward card is created for the child and sent to the mother as soon as the child's eligibility is put on file.
- Wisconsin Medicaid sends a letter to the mother, notifying her of the child's eligibility. The letter also contains a statement that the mother is required to sign, stating that the baby has continued to live with her since birth. She must send this statement to her county or tribal eligibility worker in the envelope provided and is required to tell her eligibility worker that she has a new baby with a temporary Medicaid identification number.
- A copy of this letter is also sent to the county economic support agency.
- Once the mother notifies her worker and her child has received a Social Security number, a permanent Medicaid number is assigned to the child.
- The hospital receives a copy of the eligibility notification letter sent to the child's mother as confirmation.

Providers with questions regarding newborn eligibility may contact Provider Services at (800) 947-9627 or (608) 221-9883.

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Under the Medicaid managed care contract, HMOs are required to report to Wisconsin Medicaid the birth of a newborn to a mother enrolled in an HMO.

Covered Services and Related Limitations

Inpatient Services Requirements

Wisconsin Medicaid requires that inpatient services meet all the following criteria:

- The care is directed by a physician or dentist.
- The recipient meets Wisconsin Medicaid criteria for inpatient status.
- The services are medically necessary.

Medically Necessary Care

Wisconsin Medicaid requires that inpatient services be medically necessary. HFS 101.03(96m), Wis. Admin. Code, defines "medically necessary" as a Medicaid-covered 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 the 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.

Wisconsin Medicaid considers a recipient an inpatient when the recipient is admitted to the hospital as an inpatient and is counted in the midnight census.

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The External Review Organization (ERO) performs a health care quality assurance/ utilization review of certain inpatient hospital services to determine medical necessity and appropriateness. For more information, refer to "External Review Organization Inpatient Review" in this chapter for information on the ERO under contract with the Wisconsin Department of Health and Family Services (DHFS).

Care Must Be Physician or Dentist Directed

The care and treatment of hospital inpatients are required to be under the direction of a physician or dentist in an institution certified under HFS 105.07 or 105.21, Wis. Admin. Code.

Inpatient Status

General Requirement

Wisconsin Medicaid considers a recipient an inpatient when the recipient is admitted to the hospital as an inpatient and is counted in the midnight census. In situations when a recipient inpatient admission occurs and the recipient dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the recipient is also considered an inpatient of the hospital.

Inpatient and Outpatient Services for Same Date of Service

In accordance with HFS 107.08(4)(a)4, Wis. Admin. Code, if inpatient and outpatient services are provided for the same recipient, at the same hospital, on the same date of service (DOS) as the date of the inpatient hospital admission or discharge, the outpatient services are not separately reimbursed and must be included on the inpatient claim. This does not include reference laboratory services. Include outpatient claims on the same date of admission or date of discharge for the hospital on the inpatient claim.

Under HFS 107.08(3)(c)4, Wis. Admin. Code, Wisconsin Medicaid does not reimburse outpatient claims for services provided to an inpatient in another hospital, except on the date of admission or the date of discharge. For any other day during the inpatient stay, the hospital providing the outpatient services must arrange payment with the inpatient hospital.

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Transfers

Patient transfers may be reviewed by the ERO or the DHFS for medical necessity. If the transfer is determined to have been medically necessary, both the transferring and receiving hospital will be paid the full diagnosis-related group (DRG) amount for the patient's discharge.

Transfers to Institution for Mental Disease Hospitals

An inpatient at an institution for mental disease (IMD) may transfer to an acute care general hospital, then return to the IMD and eventually be discharged from the IMD. If the patient's absence from the IMD and simultaneous stay at the acute care general hospital is *three or fewer consecutive days*, Wisconsin Medicaid reimburses the IMD for one DRG discharge payment. The recipient's payment covers the period before and the period after the stay at the acute care general hospital.

If the patient does not return to the IMD after the acute care general hospital stay, Wisconsin Medicaid reimburses the IMD one DRG payment for the patient's stay prior to his or her transfer to the acute care general hospital.

Three or fewer consecutive days means the patient is absent or on leave from the IMD for three or fewer consecutive IMD midnight census counts.

If the patient's stay at the acute care general hospital is *more than three consecutive days*, Wisconsin Medicaid reimburses the IMD with one DRG discharge payment for the patient's stay at the IMD prior to going to the acute care general hospital. If the patient returns to the IMD, Wisconsin Medicaid reimburses the IMD a second DRG discharge payment for the period after the acute care general hospital stay. In this situation, the IMD must separately bill for the two periods so that the IMD may receive two DRG discharge payments.

Wisconsin Medicaid reimburses the acute care hospital to which the patient was transferred for the medically necessary stay without regard to the patient's length of stay. The acute care hospital is paid a DRG discharge payment without regard to which condition described above applies to the IMD.

Any payment to the IMD for a patient's stay is subject to the person's eligibility for Medicaid coverage for their stay at the IMD.

Same Day Admission — Death

If a recipient is admitted and dies before the midnight census on the same day of admission, the recipient is considered an inpatient.

Same Day Admission/Discharge — Obstetrical and Newborn Stays

Wisconsin Medicaid does not have a policy on length of maternity stays. The length of a maternity stay is based on the physician's judgement of what is medically necessary. A woman may elect to be discharged on the same day she delivers. A hospital stay is

In accordance with HFS 107.08(4)(a)4, Wis. Admin. Code, if inpatient and outpatient services are provided for the same recipient, at the same hospital, on the same date of service (DOS) as the date of the inpatient hospital admission or discharge, the outpatient services are not separately reimbursed and must be included on the inpatient claim.

considered an inpatient stay when a recipient is admitted to a hospital and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This Medicaid policy applies to the baby's stay, as well as the mother's stay, and when the mother and/or newborn are transferred to another hospital.

Inappropriate Inpatient Admissions

Payment for inpatient care which could have been performed on an outpatient basis may not exceed the facility's outpatient rate-per-visit paid. If a payment has been made, Wisconsin Medicaid recovers the difference between the payment and the outpatient rate-per-visit.

Inappropriate Discharge and Readmission

If ERO determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, Wisconsin Medicaid will not issue a payment for the first discharge. Wisconsin Medicaid will recoup any payment made under these circumstances.

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Admission for Observation Purposes

In some cases, an outpatient recipient may be admitted for observation for a portion of the day. Because the recipient is not admitted as an inpatient and counted in the midnight census, he or she is not an inpatient.

Hospitals are required to obtain a case-specific control number from the ERO for all admissions subject to PAR.

Emergency Room Services

Wisconsin Medicaid considers emergency room services to be outpatient services unless the recipient is admitted to the hospital and counted in the midnight census. Refer to "Inpatient and Outpatient Services for the Same Date of Service" in this chapter for information on recipients who are admitted as inpatients after receiving emergency room services.

External Review Organization Inpatient Review

The ERO, under contract with the DHFS, reviews the quality and utilization of inpatient hospital services provided to Medicaid recipients. The ERO inpatient review includes a pre-admission review (PAR) by telephone and a retrospective medical record review of various types of hospitalizations. Refer to Appendix 3 of this section for more information about the ERO review process.

The hospital representative is also required to contact the ERO for post-admission screening of Medicaid recipients and to obtain a control number for claims submission.

Providers may contact the ERO Monday through Friday, from 8:00 a.m. to 4:30 p.m. at (800) 833-7247 or (608) 274-3832.

Case-Specific Control Number

Hospitals are required to obtain a case-specific control number from the ERO for all admissions subject to PAR. The 10-digit control number *must* appear in Item 2 of the UB-92 claim form for payment of claims.

Wisconsin Medicaid does not reimburse claims submitted for hospitalizations requiring preadmission or postadmission screening without an ERO control number.

Retrospective Inpatient Medical Record Review

The ERO's retrospective inpatient medical record review may include the following categories:

- Inpatient hospital.
- Inpatient services such as, but not limited to, operating room and recovery room services.
- Mental health/substance abuse (alcohol and other drug abuse).
- Random samples.

- Readmission within 31 days.
- Short stays.
- Suspect PAR admissions.

Each case selected for review by the ERO is reviewed for quality of care (including appropriate admission and discharge) using Division of Health Care Financing (DHCF)-approved predetermined quality of care criteria.

Medical/Surgical Review

Preadmission Review Requirements

Hospitals are responsible for contacting the ERO for PAR of the following admissions:

- All elective admissions for surgical procedures identified on ERO's outpatient procedure list. The ERO periodically revises and provides the list to hospitals.
- All elective medical admissions (excluding maintenance chemotherapy). Wisconsin Medicaid defines an elective hospitalization as an admission that may be delayed without substantial risk to the health of the patient.

Inpatient Psychiatric/Substance Abuse Review

Preadmission Review Requirements

Hospitals are responsible for contacting the ERO for PARs of the following admissions:

- All elective admissions to an IMD for patients age 65 and over.
- All elective psychiatric admissions to acute care general hospitals.
- All psychiatric admissions of individuals under age 21 to IMDs.
- All substance abuse admissions to acute care general hospitals.

A hospital representative who is knowledgeable of the patient's condition is required to contact the ERO within two working days of the patient's admission to complete the admission screening and to obtain a case-specific control number for claims submission.

Cases in which an application for Medicaid eligibility is submitted at the time of admission or at any point during an inpatient stay are subject to the ERO review process. If Wisconsin Medicaid determines that the recipient is eligible for coverage before discharge, the hospital is required to notify the ERO of the hospitalization *before* submitting their reimbursement claim to Wisconsin Medicaid so that the ERO can assign a control number for the hospitalization.

Cases in which an application for Medicaid eligibility is submitted at the time of admission or at any point during an inpatient stay are subject to the ERO review process.

Retrospective Inpatient Institution for Mental Disease Medical Record Review

The ERO retrospective inpatient IMD medical record review may include, but is not limited to, the following categories:

- Substance abuse hospitalization stays less than three days.
- Substance abuse hospitalizations identified on PAR.
- Institution for mental disease hospitalizations of individuals under the age of 21.

The ERO reviews each case for quality of care using predetermined quality criteria.

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Specific Procedure Requirements

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.

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.

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services.

Coverage of Mifeprex

Wisconsin Medicaid reimburses for Mifeprex (also 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 Healthcare Common Procedure Coding System (HCPCS) code S0190 (Mifepristone, oral, 200 mg), type of service (TOS) "1," for the first dose of Mifeprex, along with the evaluation and management (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 where Wisconsin Medicaid covers abortion.

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 personally provided the woman with certain information. 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 is not Medicaid covered.

Pursuant to s. 253.10, Wis. Stats., the DHFS has issued preprinted material summarizing the statutory requirements under s. 253.10, Wis. Stats. Providers may contact their local health departments for these materials.

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

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

Hysterectomies

Wisconsin Medicaid does not cover hysterectomy procedures if the sole or primary diagnosis is uncomplicated fibroids, fallen uterus, or retroverted uterus. Another diagnosis must coexist which, by itself, would indicate a medical need for the surgery.

Reimbursement for hysterectomies requires an Acknowledgment of Receipt of Hysterectomy Information form to be completed by the physician or hospital *before* surgery and attached to the UB-92 claim form, except in the circumstances described in the next section.

Wisconsin Medicaid does not cover hysterectomy procedures if the sole or primary diagnosis is uncomplicated fibroids, fallen uterus, or retroverted uterus. Another diagnosis must coexist which, by itself, would indicate a medical need for the surgery.

Physician Certification for Hysterectomy Performed Without Acknowledgment of Receipt of Hysterectomy Information Form

Wisconsin Medicaid may cover a hysterectomy without a valid Acknowledgment of Receipt of Hysterectomy Information form if any of the following statements are true:

- The recipient was already sterile and the physician attests to the cause of sterility. This may include menopause.
- The hysterectomy was performed during a period of retroactive recipient eligibility and the recipient was one of the following:
  - √ Informed before the operation that the procedure would make her permanently incapable of reproducing and the physician provides evidence that this was done.
  - √ Already sterile, and the physician attests to the cause of sterility.
  - √ In a life-threatening emergency situation that required a hysterectomy and the physician states the nature of the emergency.
- The hysterectomy was required because of a life-threatening emergency situation, and the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible and the physician states the nature of the emergency.

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With respect to the previous statements, Wisconsin Medicaid requires the physician to certify the circumstances in writing in a signed and dated statement, such as an Acknowledgment of Receipt of Hysterectomy Information form, or with other appropriate documentation attached to the physician's claim, such as preoperative history and physical exam documentation and an operative and pathology report.

Refer to the Physician Handbook for more information on documenting the receipt of hysterectomy information and a sample Acknowledgment of Receipt of Hysterectomy Information form.

Second Opinion

Wisconsin Medicaid requires a second opinion for payment of hysterectomies except in emergency or other special situations. Refer to the Wisconsin Medicaid Physician Handbook for more information on second opinions and second opinion waivers.

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A sterilization is any surgical procedure performed with the *primary* purpose of rendering an individual permanently incapable of reproducing.

Organ and Bone Marrow Transplants

Wisconsin Medicaid covers the following transplants and the cost of the organs, when appropriate and medically necessary, in approved hospitals as determined by Wisconsin Medicaid:

- Bone marrow.
- Cornea.
- Heart.
- Heart-lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Small bowel.

Before making a referral to an approved institution, hospitals and physicians are required to contact the facility to determine whether the facility currently accepts Medicaid recipient referrals. A partial list of Wisconsin Medicaid organ transplant institutions is included in Appendix 13 of this section. Hospital providers who seek reimbursement for recipients needing transplants (except kidney and cornea) are required to request and receive Medicaid prior authorization (PA). Refer to the Prior Authorization chapter of this section for PA information.

Transplant hospitals are required to be members of the Organ Procurement and Transplantation Network or approved by the Centers for Medicare and Medicaid Services (CMS) and have written protocols for identifying potential organ donors. Hospitals are required to obtain all organs through the organ procurement organization (OPO) designated under 42 CFR Part 486. A hospital that procures an organ in-house must abide by the rules of protocol as established by its respective OPO. Refer to Appendix 2 of this section for procedure codes for organ acquisition and storage charges.

Sterilizations

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 the surgical removal of a cancerous uterus or cancerous testicles.

Medicaid reimbursement for sterilization is dependent on providers fulfilling all federal and state requirements cited below and satisfactory completion of an informed consent statement. Federal and state regulations require that the informed consent statement meet all of the following criteria:

- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, have passed between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
  - √ 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.

- The recipient gives voluntary informed written consent for sterilization.
- The recipient is at least 21 years old on the date the informed written consent is obtained.
- 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 purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- The recipient is not institutionalized.

Documentation Requirements

When submitting claims for sterilizations, hospitals are required to attach a completed copy of the sterilization consent form with the UB-92 claim form. Refer to the Claims Submission chapter of this section for more information on submitting sterilization claims.

Hospitals are encouraged to use the Medicaid Sterilization Informed Consent form *before* all sterilizations to ensure payment in the event that the patient receives Medicaid retroactive eligibility. Refer to the Medicine and Surgery Section of the Wisconsin Medicaid Physician Services Handbook for a sample form.

If the performing physician has not done so, hospitals are required to attach a copy of the Sterilization Informed Consent form to the UB-92 claim form for Medicaid payment of sterilizations.

Sterilization Informed Consent Statement

The recipient is required to give voluntary written consent on a federally required informed consent statement. Sterilization coverage requires accurate and thorough completion of a consent form. The performing physician is responsible for obtaining consent. Any corrections to the statement are required to be signed by the physician and/or recipient, as appropriate. Refer to the Physician Services Handbook for more information on informed consent statements.

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

Institution for Mental Disease Services

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Certification of Need Requirements

Federal and state regulations require providers to conduct and document a Certification of Need (CON) assessment for all recipients under the age of 21 who are admitted to a psychiatric or substance abuse IMD for elective/urgent or emergency psychiatric or substance abuse treatment services.

Elective/Urgent Admissions

Providers are required to complete and document an elective/urgent CON assessment prior to all elective/urgent admissions for all recipients under the age of 21. Refer to Appendix 4 of this section for a reproducible Certification of Need for Elective/Urgent Psychiatric Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 form and completion instructions. Maintain completed forms in recipients' medical records.

Federal and state regulations require providers to conduct and document a Certification of Need (CON) assessment for all recipients under the age of 21 who are admitted to a psychiatric or substance abuse IMD for elective/urgent or emergency psychiatric or substance abuse treatment services.

As specified in 42 CFR Part 441.153, elective/urgent admissions require an independent team to complete the elective/urgent CON assessment. This independent team is required to meet the following requirements:

- The team is required to consist of at least two individuals, one of whom is a physician.
- The team members are required to have competence in the diagnosis and treatment of mental illness, preferably in child psychiatry.
- The individuals are required to have knowledge of the recipient's situation.

None of the members of the independent team may have an employment or consultant relationship with the admitting facility. A referring or admitting physician may be a part of the independent team if he or she does not have an employment or consultant relationship with the admitting facility and meets the independent team requirements listed above. Each team member is required to sign and date the elective/urgent CON form and state his or her credentials.

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Emergency Admissions

Providers are required to complete and document an emergency CON assessment within 14 days of admission for emergency admissions for recipients under 21 years of age.

Emergency admissions are admissions necessary to prevent death or serious impairment of the recipient's health. The hospital is responsible for ensuring that there is clinical documentation to justify an emergency admission.

Providers are required to complete and document an emergency CON assessment within 14 days of admission for emergency admissions for recipients under 21 years of age. Refer to Appendix 5 of this section for a reproducible Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission form and completion instructions. Maintain completed forms in recipients' medical records.

As specified in 42 CFR 441.153, the hospital's interdisciplinary team (which is described in 42 CFR 441.156) is responsible for performing the emergency CON assessment and completing the emergency CON form. This team is required to include, at a minimum, one of the following:

- A board-eligible or board-certified psychiatrist.
- A clinical psychologist who has a Doctoral degree and a physician licensed to practice medicine or osteopathy.
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis *and* treatment of mental diseases, and a psychologist who has a Master's degree in clinical psychology or who is certified by the Division of Supportive Living (DSL) in the DHFS as meeting the requirements for health insurance reimbursement.

The team is also required to include at least one of the following individuals:

- An occupational therapist who is licensed by the Wisconsin Department of Regulation and Licensing and who has specialized training or one year of experience in treating mentally ill individuals.
- A psychiatric social worker.
- A psychologist who has a Master's degree in clinical psychology or is certified by the DSL.
- A registered nurse with specialized training or one year of experience in treating mentally ill individuals.

Each member is required to sign and date the emergency CON form and state his or her credentials.

Documentation Requirements for Certification of Need Assessments

Providers may use the reproducible CON forms found in Appendices 4 and 5 of this section, or they may use their own, equivalent forms. Wisconsin Medicaid requires that providers' equivalent versions of the forms provide all the information that is included in Wisconsin Medicaid's versions of the CON forms. Hospitals are required to keep the CON form in the recipient's medical record according

to the requirements for retention of records in HFS 106.02(9)(b), Wis. Admin. Code.

The CON assessment and CON form are part of the retrospective review performed by the Medicaid-contracted ERO. Refer to "External Review Organization Input Review" in this chapter for more information on when a review by the ERO is necessary. These reviews include an evaluation of the CON document, which must be included in the medical record of all Medicaid recipients under the age of 21 admitted to an IMD hospital. When the ERO requests the IMD record and the CON form is either absent or not completed correctly, a technical denial letter is issued to the IMD. The technical denial letter allows the provider 20 calendar days to submit additional information.

Once the ERO has received the corrected form or missing information, the ERO completes its review of the CON compliance. Certification of Need review outcomes are reported to the DHCF on a semiannual basis. Failure to perform the CON assessment and/or properly complete the CON form will result in denied claims payment or recoveries of payments made.

Medicaid Eligibility After Admission

If a recipient becomes eligible for Wisconsin Medicaid after admission or is made retroactively eligible after discharge, the hospital's interdisciplinary team is required to complete an emergency CON assessment and the Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission form. For an individual applying for Medicaid while still in the facility, 42 CFR 441.153 requires that the certification must be made by the interdisciplinary team responsible for the plan of care and it must include any period of time before application for which claims are made. Refer to Appendix 5 of this section for a reproducible Certification of Need for Emergency Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission form and completion instructions, and to "Emergency Admissions" in this chapter for more information.

Transfers to Institutions for Mental Disease

Wisconsin Medicaid requires a CON assessment and CON form for all patient transfers when the receiving hospital is a psychiatric or substance abuse IMD. This applies even if the transferring hospital is an IMD and a CON assessment was previously completed. Providers are required to follow these procedures for elective/urgent and emergency admissions.

Noncovered Services

Under HFS 107.08(4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following:

- Unnecessary or inappropriate inpatient admissions or portions of a stay.
- Hospitalizations or portions of hospitalizations identified by the ERO for disallowance of reimbursement by Wisconsin Medicaid.
- Hospitalizations either for or resulting in surgeries which Wisconsin Medicaid considers experimental due to questionable or unproven medical effectiveness.
- Inpatient and outpatient services for the same recipient on the same DOS, unless the recipient is admitted to a hospital other than the facility providing the outpatient care.
- Hospital admissions on Friday or Saturday, except for emergencies, accident or accident care, and obstetrical cases, unless the hospital can demonstrate to the satisfaction of Wisconsin Medicaid that the hospital provides all its services seven days a week.
- Hospital laboratory, diagnostic, radiology, and imaging tests not ordered by a physician, except in emergencies.

Wisconsin Medicaid requires a CON assessment and CON form for all patient transfers when the receiving hospital is a psychiatric or substance abuse IMD.

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Wisconsin Medicaid may consider a service experimental in one setting or institution, but effective, proven, and nonexperimental in another setting depending on the facility's experience and capabilities.

Experimental Services

As specified in HFS 107.035, Wis. Admin. Code, Wisconsin Medicaid does not reimburse for experimental services. A service is considered experimental when the procedure is not generally recognized by the professional medical community as effective or proven for the condition for which it is being used.

Wisconsin Medicaid may consider a service experimental in one setting or institution, but effective, proven, and nonexperimental in another setting depending on the facility's experience and capabilities.

Institution for Mental Disease Services for Persons 21 to 64 Years of Age

In accordance with HFS 107.03(15), Wis. Admin. Code, Wisconsin Medicaid does not cover expenditures for any service to a person 21 to 64 years of age who is a resident of an IMD, unless one of the following exceptions are met:

- The recipient was a resident of the IMD immediately prior to turning 21, and has been continuously a resident up to his or her 22nd birthday.
- The recipient was on convalescent leave from an IMD.

A Medicaid recipient who is a resident of an IMD and is 21 years of age may be covered only until his or her 22nd birthday.

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Prior Authorization

In accordance with HFS 107.02(3)(b), Wis. Admin. Code, Wisconsin Medicaid requires prior authorization (PA) for certain services in order to:

- Prevent unnecessary or inappropriate care and services.
- Safeguard against excess payment.
- Assess the quality and timeliness of services.
- Determine if less expensive alternative care, services, or supplies are usable.
- Promote the most effective and appropriate use of available services and facilities.
- Curtail misutilization practices of providers and recipients.

Providers are required to obtain PA for certain specified services before providing the services, unless the service is an emergency. If the provider renders a nonemergency service that requires PA without first obtaining authorization, the provider is responsible for the cost of the service. The recipient cannot be billed for a service that would have been covered if PA was correctly obtained. For more information on PA and response time to PA requests, refer to the All-Provider Handbook.

If the provider renders a nonemergency service that requires PA without first obtaining authorization, the provider is responsible for the cost of the service.

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Services Requiring Prior Authorization

Hospitals are required to obtain PA for the following services:

- Covered hospital services if provided out of state under nonemergency circumstances by nonborder status providers.
- Hospitalization for the following transplants:
  - √ Bone marrow (including peripheral blood stem cell transplantation).
  - √ Heart.
  - √ Heart-lung.
  - √ Liver.
  - √ Lung.
  - √ Pancreas.
  - √ Small bowel.
- Most HealthCheck "Other Services."

Wisconsin Medicaid also requires hospitals to obtain PA to receive *enhanced* reimbursement rates for the following services:

- Acquired Immune Deficiency Syndrome (AIDS) — acute care.
- Acquired Immune Deficiency Syndrome — extended care.
- Brain injury care.
- Ventilator-dependent care.

The following covered services require the *performing provider* to obtain PA:

- Hospitalization for nonemergency dental services.
- Hospitalization for any other medical or surgical services noted in HFS 107.06(2), 107.07(2)(c), 107.10(2), 107.16(2), 107.17(2), 107.18(2), 107.19(2), and 107.24(3), Wis. Admin. Code. Please refer to the appropriate service-specific Medicaid handbook for inpatient hospital PA requirements for these services.

Acquired Immune Deficiency Syndrome — Acute Care

Hospitals are required to obtain PA from Wisconsin Medicaid if they seek the Medicaid special AIDS payment rate. Refer to the Inpatient Hospital State Plan for more information on AIDS PA criteria for acute and extended care. For more information on State Plans, refer to the Claims Submission chapter of this section.

To receive PA for AIDS — acute care, Wisconsin Medicaid requires that the following criteria be met:

1. The patient must be eligible for Wisconsin Medicaid.
2. The patient must have a principle diagnosis of AIDS or Human Immunodeficiency Virus (HIV) infection (*International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] code 042).
3. Upon admission, the patient must meet the intensity and severity criteria for acute care. The Department of Health and Family Services (DHFS) uses the intensity, severity, discharge indicators, and appropriate criteria to determine the appropriate level of care for the patient.
4. Sufficient documentation, such as a summary of the admission work-up, progress notes, or other supporting clinical evidence, must be provided upon request.
5. Hospitals are required to have the unique two-digit provider number suffix code, "01," to receive the AIDS — acute care — payment rate. Refer to "Services Exempt from Diagnosis-Related Group," in the Claims Submission chapter of this section for information on how to obtain the unique two-digit suffix number.

Prior authorization for the AIDS — acute care — per diem is granted for a limited period of time (usually not to exceed 30 days). If the patient will still meet the intensity and severity criteria for acute care at the time of the PA expiration date, the provider must submit another PA request for continued acute care authorization. Wisconsin Medicaid must receive the PA request on or before the expiration date because PA for continuing services may not be backdated. For more information about submitting PA requests for continued care, refer to the Prior Authorization section of the All-Provider Handbook.

Substitute the suffix number for the final two-digits of the provider number in Element 9 of the Prior Authorization Request Form (PA/RF) and in Element 7 of the Prior Authorization Physician Attachment (PA/PA). Refer to the Medicine and Surgery Section of the Wisconsin Medicaid Physician Services Handbook for a PA/PA form and completion instructions.

Acquired Immune Deficiency Syndrome — Extended Care

To receive PA for AIDS — extended care, Wisconsin Medicaid requires that the following criteria be met:

1. The patient must be eligible for Wisconsin Medicaid.
2. The patient must have a principal diagnosis of AIDS or HIV infection (ICD-9-CM code 042).
3. The patient is medically stable.
4. Reasonable attempts at securing alternative placement that allows for correct infection control procedures and isolation techniques, as documented in social services notes, must have been unsuccessful and an appropriate plan of care and discharge plan must have been established.
5. The degree of debilitation and amount of care required to care for the patient must equal or exceed the level of skilled nursing care provided in a skilled nursing facility.
6. Sufficient documentation supporting these criteria must be provided upon request.
7. Hospitals must have the unique two-digit provider number suffix code, "02," to receive the AIDS — extended care — payment rate.

Prior authorization for the extended care rate is for a defined period of time. If the patient will still meet the intensity and severity criteria for extended care at the time of the PA expiration date, the provider must submit another PA request for continued extended care authorization. Wisconsin Medicaid must receive the PA request on or before the expiration date because PA for continuing services may not be backdated. For more information about submitting PA requests for continued care, refer to the Prior Authorization section of the All-Provider Handbook.

Prior authorization for the AIDS — acute care — per diem is granted for a limited period of time (usually not to exceed 30 days).

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The DHFS recognizes that the progression of illness may require acute care services during the period established for extended care. Therefore, during this period, acute care is approved (upon receiving PA for acute care) only after the hospital has provided an acute level of care for at least five consecutive days.

The hospital is required to have the two-digit suffix number for the AIDS — extended care — payment rate. Refer to "Services Exempt From Diagnosis-Related Groups," in the Claims Submission chapter of this section, for information on how to obtain the unique two-digit suffix number. Substitute the suffix number for the final two-digits of the provider number in Element 9 of the PA/RF and in Element 7 of the PA/PA.

Hospitals are required to obtain PA for all organ transplants except kidney and cornea transplants.

Brain Injury Care

To receive the Medicaid special brain injury care payment rate, a hospital is required to be certified by Wisconsin Medicaid as a brain injury care provider. Prior authorization is also required for the brain injury care-certified hospital to receive the special payment rate. Refer to the Inpatient Hospital State Plan for more information. For information on how to obtain the state plan, refer to "Wisconsin Medicaid Inpatient and Outpatient State Plans" in the Claims Submission chapter of this section. The state plan is also available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

The hospital is required to have the two-digit suffix number for the brain injury care payment rate. Refer to "Services Exempt From Diagnosis-Related Groups," in the Claims Submission chapter of this section, for information on how to obtain the unique two-digit suffix number. Substitute the suffix number for the final two-digits of the provider number in Element 9 of the PA/RF and in Element 7 of the PA/PA.

Organ Transplants

Hospitals are required to obtain PA for all organ transplants except kidney and cornea transplants. Wisconsin Medicaid requires that the institution providing the service be approved by Organ Procurement and Transplantation Network and/or the Centers for Medicare and Medicaid Services (CMS), for performing organ transplantation.

The hospital and the transplant physician are encouraged to jointly complete and submit a PA/RF and PA/PA, including relevant patient information with the PA request.

Ventilator-Dependent Care

Hospitals are required to receive Wisconsin Medicaid PA to be eligible for the Medicaid special ventilator-dependent payment rate. The hospital is required to request approval from Wisconsin Medicaid for payment for the ventilator-dependent rate for a recipient's hospital stay, based on criteria contained in the Inpatient Hospital State Plan. For information on how to obtain the state plan, refer to "Wisconsin Medicaid Inpatient and Outpatient State Plans" in the Claims Submission chapter of this section. The state plan is also available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

To receive PA for claims reimbursement for ventilator-dependent care, the following criteria are required:

- The patient is eligible for Wisconsin Medicaid.
- The ventilator-dependent patient is medically stable.
- The hospital does not have an inpatient unit identified and approved by Wisconsin Medicaid and dedicated to the care of this type of patient.
- The patient has been hospitalized continuously for at least 30 days prior to acceptance for the ventilator rate.

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- Attempts at weaning the patient from the ventilator have failed.
- Home care is an unacceptable alternative because of financial/economic hardship or because of the lack of an adequate support system.
- Nursing home placement is inappropriate.
- The hospital has the unique two-digit provider number suffix code "04" to receive the ventilator-dependent payment rate.

The hospital is required to have the two-digit suffix number for the ventilator-dependent care payment rate. Refer to "Services Exempt from Diagnosis-Related Groups," in the Claims Submission chapter of this section, for information on how to obtain the unique two-digit suffix number. Substitute the suffix number for the final two-digits of the provider number in Element 9 of the PA/RF and in Element 7 of the PA/PA.

Procedures for Obtaining Prior Authorization

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To obtain PA, the admitting or attending physician, except for organ transplants, is required to submit a PA/RF and PA/PA. Refer to Appendices 6 and 7 of this section for a sample PA/RF and completion instructions and to the Medicine and Surgery Section of the Wisconsin Medicaid Physician Handbook for a copy of the PA/PA and completion instructions. If the physician does not submit a PA request, the hospital is encouraged to complete and submit the PA request in order to receive reimbursement for the services.

Prior Authorization Requests by Fax or Mail

Providers may submit their PA requests to Wisconsin Medicaid by fax at (608) 221-8616. To avoid delayed adjudication, do not fax and mail duplicate copies of the same PA request forms. Refer to Appendix 8 of this handbook for further guidelines on submitting PAs by fax.

To avoid delayed adjudication, do not fax and mail duplicate copies of the same PA request forms.

To request PA by mail, send completed PA forms to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers may order PA forms by writing to:

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

Please specify the type and quantity of forms needed. Reorder forms are included with each shipment; do not reorder by telephone. For more information on PA procedures, including responses to PA requests, refer to the Prior Authorization section of the All-Provider Handbook.

Claims Submission

Submitting Claims for Inpatient Services

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

Electronic Claims Submission

As an alternative to submission of paper claims, Wisconsin Medicaid can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Providers submitting electronically usually reduce their claims submission errors. Wisconsin Medicaid provides software at no charge for submitting claims electronically. For more information on obtaining electronic billing software, providers may:

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

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Wisconsin Medicaid must receive claims for coinsurance and deductibles within 365 days of the date of service (DOS) or within 90 days of the Explanation of Medicare Benefits date or the Remittance Advice date, whichever is later.

Providers who currently use the software for electronic claims submission and have technical questions may contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claims Submission

Submit claims for hospital services on the UB-92 claim form. Refer to Appendices 9 and 10 of this section for a sample UB-92 claim form and completion instructions.

For a complete set of UB-92 claim form instructions, refer to the UB-92 Billing Manual. To purchase the UB-92 Billing Manual, contact the Wisconsin Hospital Association at:

Wisconsin Hospital Association
5721 Odana Rd
Madison WI 53719-1289
(608) 274-1820
(800) 362-7121

Wisconsin Medicaid does not provide UB-92 claim forms; they *cannot* be purchased from the Wisconsin Hospital Association. UB-92 claim forms are available from many suppliers.

Mail completed UB-92 claim forms to:

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

Claims Submission Deadline

Wisconsin Medicaid must receive all claims for services provided to eligible recipients within 365 days from the date of discharge. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the Claims Submission section of the All-Provider Handbook for exceptions to the claims submission deadline and requirements for submission to late billing appeals.

Crossover Claims Submission Deadline

Claims for services provided to recipients covered by both Medicare and Wisconsin Medicaid (dual entitlees) are considered crossover claims. Wisconsin Medicaid must receive claims for coinsurance and deductibles within 365 days of the date of service (DOS) or within 90 days of the Explanation of Medicare Benefits date or the Remittance Advice date, whichever is later. This timeline applies to all initial claims submissions and resubmissions. Refer to the Claims Submission section of the All-Provider Handbook for more information on crossover claims and dual-entitlees.

Claim Components

Revenue Codes

Providers are required to enter revenue codes for accommodation and ancillary services in Item 42 of the UB-92 claim form. Refer to the UB-92 Billing Manual or Appendix 12 of this handbook section for a list of revenue codes.

Diagnosis Codes

All diagnosis codes in Items 67-76 of the UB-92 claim form must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure.

Providers may order the complete ICD-9-CM code book by writing to the address in the Provider Resources section of the All-Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Do not use codes with an "E" prefix as the primary or sole diagnosis on the UB-92 claim form.
- Do not use codes with an "M" prefix on the UB-92 claim form.

Multiple Page Claims

Wisconsin Medicaid does not accept multiple page claims for inpatient hospital stays. Providers may list a maximum of 28 lines of services on paper claims and 27 lines on electronic claims.

Coordination of Benefits

Health Insurance Coverage

Wisconsin Medicaid is generally the payer of last resort for Medicaid-covered services. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on programs that pay after Wisconsin Medicaid. If the recipient is covered under other health insurance, such as Medicare or commercial health insurance, Wisconsin Medicaid reimburses that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring other health insurance billing.

Medicaid Managed Care Coverage

For recipients enrolled in a Medicaid managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization (PA) for hospital services. Wisconsin Medicaid denies claims for services covered by a Medicaid managed care program.

If a recipient is fee-for-service on his or her date of admission, but is enrolled in a Medicaid HMO before discharge, submit the entire inpatient claim to Medicaid fee-for-service as an "extraordinary claim."

Submit extraordinary claims to:

Wisconsin Medicaid
Extraordinary Claims
6406 Bridge Rd
Madison WI 53784-6470

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If an enrollee is in a Medicaid HMO at the time of admittance and is disenrolled during the hospital stay, this is not an extraordinary claim. Submit the entire inpatient claim to the recipient's HMO.

Refer to the Wisconsin Medicaid Managed Care Guide for information about managed care program noncovered services, emergency services, and hospitalizations.

For recipients enrolled in a Medicaid managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization (PA) for hospital services.

Medicare/Medicaid Dual-Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual-entitlees. Hospitals are required to send claims for Medicare-covered services provided to dual-entitlees to Medicare before submitting claims to Wisconsin Medicaid.

If the service for a dual-entitlee is covered by Medicare, but Medicare denies the claim for any reason besides denial code "M7," indicate a

Medicare disclaimer code in Item 84 of the UB-92 claim form. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about crossover claims.

Medicare does not require PA for its covered services, but providers are strongly encouraged to obtain Wisconsin Medicaid PA for hospital services that require PA before the services are provided to dual-entitlees. Wisconsin Medicaid requires a PA number on noncrossover institutional claims submitted for dual-entitlees if the services provided require Medicaid PA.

Dual-Entitlement During Inpatient Stay

If a recipient becomes eligible for both Medicare and Wisconsin Medicaid during an inpatient stay, submit the claim to Medicare first. When Medicare benefits are exhausted mid-stay, indicate value code "83" in Item 39a to 41b, with the Medicare Part A payable charges as the value amount. Refer to Appendix 14 of this section for dual-entitlee billing instructions for recipients with partial or no Medicare Part A coverage during an inpatient hospital stay.

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End-Stage Renal Disease Services

Dialysis for end-stage renal disease (ESRD) is a covered service for Medicare as well as for Wisconsin Medicaid.

Medicaid covers swing-bed claims only for dual-entitlees.

Claims for ESRD services automatically crossover to Wisconsin Medicaid from Medicare. Claims submitted to Medicare must indicate the following items on the UB-92 claim form to ensure proper claims processing with Wisconsin Medicaid:

- Indicate covered days in Item 7.
- Indicate "T-19" in Item 50.
- Indicate the recipient's Medicaid identification number in Item 60.

If the service for a dual-entitlee is covered by Medicare, but Medicare denies the claim, indicate a Medicare disclaimer code in Item 84 of the UB-92 claim form.

Wisconsin Medicaid will reimburse only for ESRD services billed as Medicare crossover claims, with two exceptions:

- A recipient may not be eligible for Medicare benefits for the first three months of dialysis treatment. The Medicare disclaimer code "M-6" may be used when billing for services provided during this period.
- Wisconsin Medicaid will reimburse renal-related services if the recipient is not eligible for Medicare benefits *and cannot become eligible* for Medicare benefits. Providers are required to use Medicare disclaimer code "M-6" in this situation.

In these situations, providers are required to use only Medicare disclaimer code "M-6." Wisconsin Medicaid monitors the use of any other Medicare disclaimer code for renal-related services, and misuse is subject to recovery.

Swing-Bed Services

Rural hospitals with fewer than 100 beds can receive approval from the Centers for Medicare and Medicaid Services (CMS) for beds to be used interchangeably as hospital and skilled nursing facility beds. If hospital beds are used as skilled nursing facility beds, the services provided to the recipients in the beds are considered swing-bed services.

Medicaid covers swing-bed claims only for dual-entitlees. These claims automatically cross over to Wisconsin Medicaid from Medicare.

Wisconsin Medicaid pays only the coinsurance and deductible amount on Medicare crossover claims for swing-bed services and does not pay swing-bed services that Medicare denies. Swing-bed services are not paid on Medicaid-only claims because they are not a Medicaid-covered service.

Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary (QMB)-Only recipients are eligible only for Medicare monthly insurance premium payments for Part A coverage (if payable), Part B coverage, and Wisconsin Medicaid payment of the coinsurance and the deductible for Medicare-covered services. For more information about QMB-Only status, refer to the All-Provider Handbook.

Usual and Customary Charges

Providers are required to bill their usual and customary charge for any services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient.

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 a non-Medicaid patient. Providers shall not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

Special Circumstances

Change of Ownership Billing

The date of discharge governs which provider number is used when a change of hospital ownership occurs. For example: A change of ownership occurs on July 1. A patient stay has DOS from June 26 to July 2. The hospital submits the claim using the provider number effective July 1.

Dilation and Curettage

When submitting a claim for dilation and curettage surgical procedures, hospitals are required to attach a copy of the preoperative history and physical exam document and an operative and pathology report with the UB-92 claim form.

Discharge Billing Requirements

Drugs, durable medical equipment, and disposable medical supplies provided at discharge are not reimbursable services for inpatient hospitals. Providers who submit claims for these services are required to be appropriately certified as pharmacies or individual medical suppliers and follow the policies and procedures for their provider type.

Inpatient and Outpatient Services for Same Date

If inpatient and outpatient services are provided for the same recipient, at the same hospital, on the same date as the date of the inpatient hospital admission or discharge, the outpatient services are not separately reimbursed and are required to be included on the inpatient claim. This does not include reference laboratory services.

Wisconsin Medicaid does not reimburse outpatient claims for services provided to a recipient who is also receiving inpatient services in another hospital, except on the date of admission or the date of discharge. For any other day during the inpatient stay, the hospital providing the outpatient services is required to arrange payment with the inpatient hospital.

Leaves of Absence

Wisconsin Medicaid does not cover recipient leaves of absence from an inpatient hospital. Use revenue code 180 for all days the recipient was not present at the midnight census. Indicate the total leave days in Item 46 (units) on the UB-92 claim form.

Major Organ or Bone Marrow Transplants

Include the following items on inpatient transplant claims:

- Eight-digit Medicaid provider identification number.
- *International Classification of Diseases, Ninth Revision, Clinical Modification* surgical procedure code.

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 a non-Medicaid patient.

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- Local Healthcare Procedure Coding System (HCPCS) code for each type of organ or bone marrow acquisition and storage charge. Refer to Appendix 2 of this section for a list of applicable HCPCS codes.
- Medicaid-assigned PA number.

All paid Medicaid transplant claims are required to be included in the Medicaid portion of the filed cost report. Refer to the Inpatient Hospital State Plan for information on cost reports. In addition, hospitals are required to prepare a separate Schedule D-6, Part I, of the Inpatient Hospital State Plan on the cost report for every type of organ acquisition cost for those Medicaid transplants performed.

All paid Medicaid transplant claims are required to be included in the Medicaid portion of the filed cost report.

Wisconsin Medicaid does not reimburse providers for organ transplants or transplant-related services provided to illegal aliens.

Noncovered Days and Noncovered Charges

For hospital admissions, the entire length of stay is required to be shown in the "Statement Covers Period" even if the recipient is not eligible for the entire stay, or if part of the stay is not covered. Wisconsin Medicaid does not reimburse the date of discharge; while the date of discharge is indicated in Item 6 of the UB-92 claim form, it should not be counted in Item 7.

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Obstetrical and Newborn Stays

Claims for One-Day Mother/Baby Stays

Providers are required to submit a UB-92 inpatient claim for the mother or the baby by following these procedures:

- Indicate bill type "111" for inpatient services in Item 4.
- Indicate the "From" and "To" dates in Item 6 (they must be the same).
- Indicate the covered days as "1" in Item 7.

The diagnosis codes and procedure codes must result in the claim being assigned to one of the diagnosis-related groups (DRGs) in range 601-680 (newborn) or any delivery including Cesarean section transfers. For more information on DRGs, refer to "Payment Methods" in this chapter.

Claims for Newborns Using Mothers' Medicaid Identification Numbers

Providers may submit a newborn's claim using the mother's Medicaid identification number if the baby's hospital stay is 10 days or less from the baby's date of birth and a Medicaid identification number has not been assigned to the baby. If the baby's hospital stay is 11 or more days, submit the claim with the baby's Medicaid identification number when assigned.

Wisconsin Medicaid requires hospitals to indicate the following information when submitting a newborn claim under the mother's number:

- The baby's name in Item 12 of the UB-92 claim form (i.e., Smith, Newborn).
- The occurrence code (50 — male, 51 — female) in Items 32-35.
- The baby's date of birth with the occurrence code.
- The mother's name and her date of birth in Item 58.
- The mother's Wisconsin Medicaid identification number in Item 60.

Claims submitted under the baby's Medicaid identification number do not need an occurrence code with a date of birth and do not need to indicate the mother's Medicaid identification number.

For multiple births, submit a separate UB-92 claim form for each newborn.

Establishing Continuous Eligibility of Newborns

According to federal law, an infant who remains in his or her mother's household may continue to receive Wisconsin Medicaid benefits until the end of the month in which the child turns one year old, regardless of changes in family size or income. Once the infant is one year old, eligibility will be based on family income and size. The family is responsible for reporting these changes.

Wisconsin Medicaid applies Medicaid eligibility for newborns from the date of birth through the month in which the child turns one year of age. These policies are for newborns born to mothers who are eligible for Wisconsin Medicaid including Healthy Start and whose birth is reported by hospitals.

If a mother was not a Medicaid recipient when the baby was born, she can retroactively apply for Wisconsin Medicaid. If her dates of eligibility include the date of the baby's birth, her baby may also receive retroactive eligibility and continuous eligibility for the first year of life.

Transfers Between Units Within a Hospital

Patients who are transferred from one hospital unit to another within the same hospital are not considered discharged until the entire hospital stay has ended. Wisconsin Medicaid considers a discharge as occurring when the patient leaves the hospital for any reason other than a "leave of absence." Wisconsin Medicaid pays hospitals one DRG per stay and does not recognize specialty rehabilitation or psychiatric units for separate reimbursement purposes. Refer to "Diagnosis-Related Groups" in this chapter for more information on DRGs.

Payment Methods

Wisconsin Medicaid Inpatient and Outpatient State Plans

The Hospital Inpatient and Outpatient State Plans are Wisconsin Medicaid's federally approved description of methods and standards for establishing payment rates to providers. The State Plans include all hospital inpatient and outpatient rate-setting methodologies. The State Plans are effective from July 1 to June 30. Wisconsin Medicaid amends the State Plans at least once each year. Hospitals are allowed an opportunity to comment on proposed amendments before Wisconsin Medicaid requests approval from CMS for state plan changes.

Providers may obtain copies of the state plan on the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*. Refer to the Inpatient Hospital State Plan for more information about the following:

- Administrative adjustment actions.
- Border status hospital and cost reports.
- Disproportionate share.
- Hospital outlier trim points.
- Out-of-state, nonborder status inpatient hospital stays.

Diagnosis-Related Groups

Wisconsin Medicaid uses a payment system for certified in-state, out-of-state, and border-status hospitals based on DRGs. The DRG system covers the following:

- Acute care general hospitals.
- Institution for mental disease (IMD) hospitals, except state-operated IMD hospitals.

The following are excluded from the DRG system and are paid under a hospital-specific daily rate:

- Rehabilitation hospitals.
- State-operated IMD hospitals.
- State-operated veteran's hospitals.

Hospital Services Included in the Diagnosis-Related Group-Based Payment System

Most Medicaid-covered services provided during an inpatient stay are hospital inpatient services that are included in the DRG-based payment system. Wisconsin Medicaid also considers the following hospital services as part of the DRG-based payment system:

- Drugs, except take-home drugs on the date of discharge.
- Services by independent therapists (physical therapy, occupational therapy, speech therapy, etc.).
- Services of residents and interns.

Patients who are transferred from one hospital unit to another within the same hospital are not considered discharged until the entire hospital stay has ended.

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- Services provided by another hospital (except on the date of admission and discharge).
- Services provided by social workers and substance abuse (alcohol and other drug abuse) counselors.
- Technical services by independent imaging groups (X-ray, MRI, etc.).
- Technical services provided by a nonhospital laboratory.

Any other services, including professional services, are not covered under the DRG payment.

Services Exempt from Diagnosis-Related Groups

Payment for certain specialized inpatient services are exempt from the DRG system. These services can receive enhanced reimbursement by obtaining Medicaid PA. The following are exempted services:

- Brain injury cases.
- Negotiated payments for unusual cases.
- Recipients with Acquired Immune Deficiency Syndrome (AIDS).
- Ventilator-dependent recipients.

Hospitals may interim bill for DRG claims if the recipient has been an inpatient at the hospital for more than 120 days.

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Refer to the Inpatient Hospital State Plan for special provisions for payment of each of these DRG-exempted services.

To be eligible for reimbursement and to request PA in order to be paid for AIDS, ventilator-dependent, or brain injury cases, providers are required to obtain a separate suffix provider number, which replaces the last two digits of the original eight-digit provider Medicaid identification number. Negotiated payments for unusual cases do not require a separate suffix provider number.

To obtain a unique two-digit suffix number for AIDS, ventilator-dependent, or brain injury cases, hospitals must complete the form in Appendix 1 of this section.

Once the hospital provider is notified of the unique two-digit suffix number, the hospital provider requests a DRG exemption PA using this unique provider number. Refer to the Prior Authorization chapter of this section for more information on PA.

For more information, providers may contact Wisconsin Medicaid's Hospitals, Physicians, and Clinics Unit at:

> Division of Health Care Financing
> Hospitals, Physicians, and Clinics
> PO Box 309
> Madison WI 53701-0309

Interim Payment for Long Length of Stay

Hospitals may interim bill for DRG claims if the recipient has been an inpatient at the hospital for more than 120 days. Submit claims for interim payment with patient status code "30" (still a patient) in Item 22 of the UB-92 claim form.

To receive final payment for the claim, submit an adjustment to the original claim. Refer to the Claims Submission section of the All-Provider Handbook for more information on how to submit claims adjustments.

If additional interim payments are necessary, use an adjustment form for the subsequent requests. At least 30 additional days are required to elapse since the "through" date on any previous claim or adjustment. Write "interim payment for long length of stay" as the adjustment reason. Attach an updated UB-92 claim form to the request. On the updated UB-92 claim form include:

- A current patient status code in Item 22.
- All accumulated charges since admission (not just the additional charges since the first interim payment).
- All other updated information showing all events up to the "through" date on the

claim (e.g., additional surgical procedure codes, new discharge diagnosis).

Retroactive Rate Adjustments

Wisconsin Medicaid automatically generates retroactive rate adjustments for any paid inpatient claim with dates of discharge on or after the effective date of a rate change back to the authorized effective date of the rate change. No additional action is required by the hospital to receive the rate adjustment.

For example: The legislature approves rate changes for dates of discharge on and after July 1, but does not finalize the change until September 1. In this case, Wisconsin Medicaid retroactively adjusts all paid claims with dates of discharge between July 1 and September 1. Both DRG payments and outliers are adjusted for the change.

Follow-Up to Claims Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status 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 for processing.

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 more information on:

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

Wisconsin Medicaid automatically generates retroactive rate adjustments for any paid inpatient claim with dates of discharge on or after the effective date of a rate change back to the authorized effective date of the rate change.

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Appendix

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Appendix 1
Request for Unique Suffix Number for Acquired Immune Deficiency Syndrome, Ventilator-Dependent, or Brain Injury Cases
(for photocopying)

(A copy of the Request for Unique Suffix Number for Acquired Immune Deficiency Syndrome, Ventilator-Dependent, or Brain Injury Cases form is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1168 (Rev. 04/02)

STATE OF WISCONSIN

REQUEST FOR UNIQUE SUFFIX NUMBER FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME, VENTILATOR-DEPENDENT, OR BRAIN INJURY CASES

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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.

Completion and retention of this form is required under s. 7000 of the Hospital Inpatient State Plan. Failure to complete and submit this form may result in denial of Medicaid payment for the services.

INSTRUCTIONS

1. Type or print clearly.
2. Check the box to indicate which suffix number(s) is being requested.
3. The Wisconsin Medicaid provider number must be the first six digits of your provider number plus the two-digit suffix number. Use the chart below for the appropriate suffix number.
4. For more information on obtaining suffix numbers, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Type of Service	Suffix Number	Check Desired Categories
Acquired Immune Deficiency Syndrome (AIDS) — acute care	01	
AIDS — extended care	02	
Ventilator — long-term services	04	
Brain injury — out-of-state	80	
Brain injury — neuro-behavioral	81	
Brian injury — coma-stem	82	

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Name — Provider	Wisconsin Medicaid Provider Number (eight digits)

Check the pertinent options below:

☐ This facility plans to request the special payment rate for services provided to recipients with Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection in the future.

☐ This facility has an inpatient unit devoted solely to the care of recipients who are ventilator dependent and requests to be assigned the appropriate suffixes for the special payment rate for services provided to ventilator-dependent recipients in the future.

☐ This facility does not have an inpatient unit devoted solely to the care of recipients who are ventilator dependent and requests to be assigned the appropriate suffixes for the special payment rate for services provided to ventilator-dependent recipients in the future.

☐ This facility plans to request the special payment rate for services provided to recipients with brain injury in the future.

SIGNATURE — Authorized Hospital Staff Member	Date Signed

Mail completed forms to the following address:

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

Appendix 2
Procedure Codes for Organ Acquisition and Storage Charges

Use one of the following procedure codes for major organ or bone marrow transplants in Item 44 of the UB-92 claim form:

Procedure Codes	Description
W9110	Heart transplants
W9111	Lung transplants
W9112	Liver transplants
W9113	Pancreas transplants
W9114	Kidney transplants
W9115*	Bone marrow transplants (when donor is located in another hospital)

*Do not add W9115 if the donor is located in the *same* hospital and applicable charges are made directly on the recipient's claim.

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Appendix 3
External Review Organization Review Process

Pre-Admission Review by Telephone

Refer to the Covered Services and Related Limitations chapter of this section for the types of admissions requiring pre-admission review (PAR). At the time the physician or hospital contacts the External Review Organization (ERO), an ERO nurse reviewer determines whether the admission is subject to review procedures and, if so, gathers information over the telephone regarding the patient's medical condition. The ERO reviewer uses Wisconsin Medicaid psychiatric/substance abuse (alcohol and other drug abuse) and medical/surgical criteria to determine whether on the basis of information provided the admission appears to be medically necessary. If the reviewer determines that the admission might be "suspect" (e.g., not medically necessary):

- The ERO reviewer informs the provider that the admission is suspect.
- The ERO "flags" the case for retrospective review.

A preliminary determination by the ERO that the medical necessity of the admission is "suspect" is made during the telephone review if the admission does not meet the criteria for admission *or* if there is not adequate information to determine whether the criteria are met.

The ERO issues a unique control number for all admissions at the time of the telephone review. Claims for admissions subject to this review process that do not have a control number are denied.

Complete medical record documentation is essential for the ERO at the time of the telephone interview and hospitalization. Physicians must be certain that the patient's record continually and adequately documents the recipient's condition and need for inpatient care.

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Retrospective Medical Record Review

The ERO under contract with the Department of Health and Family Services (DHFS) routinely performs retrospective medical record review of "suspect" and other admissions identified by the DHFS. Review categories may include:

- Mental health/substance abuse.
- Medicaid fee-for-service hospital claims.
- Random samples.
- Readmission within 31 days.
- Short stays.
- Suspect PAR admissions.

If a case is selected for retrospective review, the ERO requests the recipient's medical record from the hospital. If upon retrospective review, the ERO determines that the admission or any portion of the inpatient stay was not medically necessary, the ERO informs the hospital and Wisconsin Medicaid of their final determination. All cases selected for review shall undergo quality of care review.

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Appendix 4
Certification of Need for *Elective/Urgent* Psychiatric Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21
(for photocopying)

(A copy of the Certification of Need for Elective/Urgent Psychiatric Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 form is located on the following page.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11047 (Rev. 08/03)

STATE OF WISCONSIN
HFS 107.13, Wis. Admin. Code

WISCONSIN MEDICAID

CERTIFICATION OF NEED FOR ELECTIVE / URGENT PSYCHIATRIC/SUBSTANCE ABUSE ADMISSIONS TO HOSPITAL INSTITUTIONS FOR MENTAL DISEASE FOR RECIPIENTS UNDER AGE 21

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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.

Completion and retention of this form is required under s. 7000 of the Hospital Inpatient State Plan. Failure to complete and submit this form may result in denial of Medicaid payment for the services.

INSTRUCTIONS

1. Type or print clearly.
2. All requested information must be provided, including physician and team member credentials. Providers may use their own version of this form as long as it includes all the same information.
3. Persons completing this form must be members of an independent team that:
   - Do not have an employment or consultant relationship with the admitting facility.
   - Includes a physician.
   - Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.
   - Have knowledge of the recipient's situation.
4. The physician and team members signing this form must sign their full names and write their credentials; initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is acceptable as long as the hospital institution for mental disease (IMD) has written policies and procedures covering these signatures. Verbal orders and/or telephone orders are acceptable, but they must be cosigned by the physician giving the order and the date of the cosignature of the physician must be written beside the signature. The hospital IMD written policies and procedures must state the allowed time by which a verbal order or telephone order must be cosigned by the physician. The signature must be dated within this time frame for it to be accepted.
5. If the signature and completion dates indicated on the form differ, the Certification of Need (CON) form will be presumed to have been completed on the latest date indicated on the form.
6. Retain the completed form in the recipient's medical record.
7. For more information about CON procedures, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

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SECTION I — RECIPIENT INFORMATION

Name — Recipient	Wisconsin Medicaid Identification Number (10 digits)	Date of Birth (MM/DD/YYYY)

SECTION II — FACILITY INFORMATION

Name — Admitting Facility	Wisconsin Medicaid Provider Number (eight digits)	External Review Organization Control Number
Address — Admitting Facility (Street, City, State, and Zip Code)		Date of Admission (MM/DD/YYYY)

We hereby certify the following:

- Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Name — Physician (print)

SIGNATURE — Physician	Credentials	Date Signed
SIGNATURE — Other Team Member	Credentials	Date Signed
SIGNATURE — Other Team Member	Credentials	Date Signed

Date of CON Form Completion (MM/DD/YYYY)

Appendix 5
Certification of Need for *Emergency* Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission
(for photocopying)

(A copy of the Certification of Need for *Emergency* Psychiatric/Substance Abuse Admissions to Hospital Institutions for Mental Disease for Recipients Under Age 21 and in Cases of Medicaid Determination After Admission form is located on the following page.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11048 (Rev. 08/03)

STATE OF WISCONSIN
HFS 107.13, Wis. Admin. Code

WISCONSIN MEDICAID

CERTIFICATION OF NEED FOR EMERGENCY PSYCHIATRIC / SUBSTANCE ABUSE ADMISSIONS TO HOSPITAL INSTITUTIONS FOR MENTAL DISEASE FOR RECIPIENTS UNDER AGE 21 AND IN CASES OF MEDICAID DETERMINATION AFTER ADMISSION

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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.

Completion and retention of this form is required under s. 7000 of the Hospital Inpatient State Plan. Failure to complete and submit this form may result in denial of Medicaid payment for the services.

INSTRUCTIONS

1. Type or print clearly.
2. All requested information must be provided, including physician and team member credentials. Providers may use their own version of this form as long as it includes all the same information.
3. Persons completing this form must be members of the interdisciplinary team responsible for the plan of care for this recipient, as described in 42 CFR 441.156.
4. The physician and team members signing this form must sign their full names and write their credentials; initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is acceptable as long as the hospital institution for mental disease (IMD) has written policies and procedures covering these signatures. Verbal orders and/or telephone orders are acceptable, but they must be cosigned by the physician giving the order and the date of the cosignature of the physician must be written beside the signature. The hospital IMD written policies and procedures must state the allowed time by which a verbal order or telephone order must be cosigned by the physician. The signature must be dated within this time frame for it to be accepted.
5. If the signature and completion dates indicated on the form differ, the Certification of Need (CON) form will be presumed to have been completed on the latest date indicated on the form.
6. Retain the completed form in the recipient's medical record.
7. For more information about CON procedures, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

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Refer to the Online Handbook
for current policy

Check one:

☐ Emergency Admission ☐ Medicaid Eligibility After Admission

SECTION I — RECIPIENT INFORMATION

Name — Recipient	Wisconsin Medicaid Identification Number (10 digits)	Date of Birth (MM/DD/YYYY)

SECTION II — FACILITY INFORMATION

Name — Admitting Facility	Wisconsin Medicaid Provider Number (eight digits)	External Review Organization Control Number
Address — Admitting Facility (Street, City, State, and Zip Code)		Date of Admission (MM/DD/YYYY)

We hereby certify the following:

- Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Name — Physician (print)

SIGNATURE — Physician	Credentials	Date Signed
SIGNATURE — Other Team Member	Credentials	Date Signed
SIGNATURE — Other Team Member	Credentials	Date Signed

Date of CON Form Completion (MM/DD/YYYY)

Appendix 6
Prior Authorization Request Form (PA/RF) Completion Instructions for Inpatient Hospital Services

Element 1 — Processing Type
Enter the appropriate three-digit processing type from the list below. The "processing type" is a three-digit code used to identify a category of service requested.

117 — Physician Services (includes Family Planning Clinics and Rural Health)
133 — Transplant Services
134 — Acquired Immune Deficiency Syndrome (AIDS) Services (hospital and nursing home)
135 — Ventilator Services (hospital and nursing home)
999 — Other (use only if the requested category of services is not listed above)

Element 2 — Recipient's Medical Assistance ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient'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 4 — Recipient Address
Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

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Element 5 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

Element 6 — Sex
Enter an "X" to specify the recipient's gender as male or female.

Element 7 — Billing Provider Name, Address, ZIP Code
Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number
Enter the billing provider's telephone number, including area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.
Enter the billing provider's eight-digit Medicaid provider number. For AIDS, ventilator-dependent, or other care, substitute the unique suffix number for the final two digits of the provider number.

Element 10 — Dx: Primary
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code
Enter the appropriate procedure code for each service/procedure/item requested.

Element 15 — MOD
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 — POS
Enter the Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	*Description*
1	Inpatient Hospital/Ambulatory Surgical Center

Element 17 — TOS
Enter the appropriate Medicaid single-digit type of service code for each service/procedure/item requested.

Numeric Code	*Description*
0	Blood
1	Medical (Physician's Medical Services, Home Health, Independent Nurses, Audiology, Physical Therapy, Occupational Therapy, Speech and Language Pathology, Personal Care, Substance Abuse [Alcohol and Other Drug Abuse], Day Treatment, and Substance Abuse Day Treatment)
2	Surgery
3	Consultation
4	Diagnostic X-Ray — Total Charge
5	Diagnostic Lab — Total Charge
6	Radiation Therapy — Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other, including: Transportation Non-MD Psych (nonboard operated only) Family Planning Clinic Rehabilitation Agency Nurse Midwife Chiropractic

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Alpha Code	*Description*
C	Ancillaries, Hospital Outpatient Services, Mental Health Psychotherapy and Evaluations, Diagnostic Testing, Substance Abuse Services, and Nursing Home
E	Accommodations, Hospital, and Nursing Home
X	Diagnostic Lab — Professional

Element 18 — Description of Service
Enter a written description corresponding to the appropriate code for each service/procedure/item requested.

Element 19 — QR

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

- Brain Injury Care Services (number of days).
- Hospital Transplant (per hospital stay).
- Hospital and Nursing Home AIDS Services (number of days).
- Hospital and Nursing Home Ventilator Services (number of days).

Element 20 — Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the Prior Authorization Request Form (PA/RF) should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Service's *Terms of Provider Reimbursement.*

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

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Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.

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Refer to the Online Handbook
for current policy

Appendix 7
Sample Prior Authorization Request Form (PA/RF) for Inpatient Hospital Services

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 133

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima D.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: 09/25/1975
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (555) 555-5555
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555
9 BILLING PROVIDER NO.: 12345678
10 DX: PRIMARY: 203.0 Multiple myeloma
11 DX: SECONDARY:
12 START DATE OF SOI:
13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
41.01		1	0	Autologous bone marrow transplant		$100,000.00
W9115		1	C	Acquisition cost		
					TOTAL CHARGE	21 $100,000.00

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22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY DATE
24 I.M. Provider REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED
GRANT DATE
EXPIRATION DATE
PROCEDURE(S) AUTHORIZED
QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

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for current policy

Appendix 8
Prior Authorization by Fax Guidelines

Providers may fax prior authorization (PA) requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any Wisconsin Medicaid fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to Wisconsin Medicaid, providers should be aware of the following:

- Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the time frames outlined in the Prior Authorization section of the All-Provider Handbook.
- Faxed PA requests must be received by 1:00 p.m., otherwise, they will be considered as received the following business day. Faxed PA requests received on Saturday, Sunday, or a holiday will be processed on the next business day.
- After faxing a PA request, providers should not send the original paperwork, such as the carbon Prior Authorization Request Form (PA/RF), by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.
- Providers may not photocopy and reuse the same PA/RF for other requests. When submitting a new request for PA, it must be submitted on a new PA/RF so that the request is processed under a new PA number. This requirement applies whether the PA request is submitted by fax or by mail.
- When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments, which includes Wisconsin Medicaid's 15-digit internal control number located on the top half of the PA/RF. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.
- When faxing information to Wisconsin Medicaid, providers *should not* reduce the size of the PA/RF to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.
- If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.
- Refaxing a PA request before the previous PA request has been returned will create duplicate PA requests and may result in delays.
- If the provider does not indicate his or her fax number, Wisconsin Medicaid will mail the decision back to the provider.
- Wisconsin Medicaid will attempt to fax a PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

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Appendix 9
UB-92 Claim Form Completion Instructions for Inpatient Hospital Services

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

These instructions are for the completion of the UB-92 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at www.dhfs.state.wi.us/medicaid/ for more information about the EVS.

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for current policy

Item 1* — Provider Name, Address, and Telephone Number
Enter the name of the hospital submitting the claim and the complete mailing address to which the hospital wishes payment sent. Include the hospital city, state, and ZIP code.

Item 2 — ERO Assigned Number (required, if applicable)
Enter the Pre-Admission Review control number if required.

Item 3 — Patient Control No.
Enter the patient's control number.

Item 4 — Type of Bill
Enter the three-digit type of bill number. The bill number for inpatient hospitals is:

111 = Hospital, Inpatient, Admit through Discharge Claim

Item 5 — Fed. Tax No. (Not required)

Item 6 — Statement Covers Period (from - through)
Enter both dates in MMDDYY format (e.g., May 9, 2003, would be 050903).

Item 7 — COV D.
Enter the total number of days covered by the primary payer, as qualified by the payer organization such as commercial health insurance or Medicare. Do not count the day of discharge.

Item 8 — N-C D.
Enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the "from - through" period.

Item 9 — C-I D (Not required)

Item 10 — L-R D (Not required)

Item 11 — Unlabeled Field (reserved for state use)

Item 12 — Patient 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.

*Items are also referred to as "Form Locators" in the UB-92 Billing Manual.

Item 13 — Patient Address (not required)

Item 14 — Birthdate (not required)

Item 15 — Sex (not required)

Item 16 — MS (not required)

Item 17 — Admission Date
Enter the admission date in the MMDDYY format (e.g., 050103).

Item 18 — Admission HR (not required)

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Item 19 — Admission Type
1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn

Item 20 — Admission SRC
Enter the code indicating the source of this admission. Refer to the UB-92 Billing Manual for more information on this item.

Item 21 — D HR (not required)

Item 22 — STAT
Enter the code indicating patient status as of the "Statement Covers Period" through date (Item 6).

Item 23 — Medical Record No.
Enter the number assigned to the patient's medical/health record by the provider.

Items 24-30 — Condition Codes (required, if applicable)

Item 31 — Unlabeled Field (reserved for state use)

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

Item 36 — Occurrence Span (Codes and From-Through) (required, if applicable)

Item 37 a-c — Unlabeled Field (reserved for state use)

Item 38 — Unlabeled Field (reserved for state use)

Items 39-41 a-d — Value Codes (Codes and Amounts) (required, if applicable)

Item 42 — REV. CD.
Enter the revenue code which identifies a specific accommodation, ancillary service, or billing calculation.

Item 43 — Description
Enter a description for the revenue code(s) listed in Item 42.

Item 44 — HCPCS/Rates (required, if applicable)
Enter the rate for each accommodation revenue code indicated.

Item 45 — Serv. Date (not required)

Item 46 — Serv. Units
Enter the total number of covered accommodation days, ancillary units of service, or visits, where appropriate.

Item 47 — Total Charges
Enter the total charges pertaining to the related revenue code for the current billing period as entered in Item 6.

Item 48 — Non-covered Charges (not required)

Item 49 — Unlabeled Field (reserved for state use)

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Item 50 A-C — Payer
Identify all third-party payers (including Medicare and commercial health insurance). Enter "T19" for Wisconsin Medicaid and "MED" for Medicare. For a list of identifiers for commercial health insurance, refer to the UB-92 Billing Manual.

Item 51 A-C — Provider No.
Enter the number assigned to the provider by the payer indicated in Item 50 A, B, and C.

Item 52 A-C — Rel Info (not required)

Item 53 A-C — Asg Ben (not required)

Item 54 A-C — Prior Payments (required, if applicable)
There must be a dollar amount or $0.00 reported here for the third-party payer identified in Item 50. Do not indicate any Medicare payments.

Item 55 A-C — Est Amount Due (not required)

Item 56 — Unlabeled Field (reserved for state use)

Item 57 — Unlabeled Field (reserved for state use)

Item 58 A-C — Insured's Name
If submitting a claim for a newborn and using the mother's Medicaid identification number, both the mother's name and birth date should be indicated here.

Item 59 A-C — P. Rel (not required)

Item 60 A-C — Cert. — SSN — HIC. — ID No.
Enter the recipient's 10-digit Medicaid identification number as it appears on his/her identification card.

Note: When the hospital stay involves a birth(s), each baby's charges must be submitted on a separate claim form. If the entire stay is less than 11 days, the hospital may submit the baby's claim using the mother's Medicaid identification number, identifying the baby's sex with occurrence code 50 or 51 and indicating the occurrence (birth) date. Otherwise, the claim should be submitted using the baby's Medicaid identification number, once assigned.

Item 61 A-C — Group Name (not required)

Item 62 A-C — Insurance Group No. (not required)

Item 63 A-C — Treatment Authorization Codes (required, if applicable)
Indicate the approved seven-digit Wisconsin Medicaid prior authorization number.

Item 64 — Esc (not required)

Item 65 — Employer Name (not required)

Item 66 — Employer Location (not required)

Item 67 — Prin. Diag. CD.
The principal diagnosis code identifies the condition chiefly responsible for the patient's visit or treatment. Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis.

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Manifestation codes are not to be recorded as the principal diagnosis; code the underlying disease first. The principal diagnosis code may not include "E" codes. "V" codes may be used as the principal diagnosis, *unless restricted by the payer*.

Items 68-75 — Other Diag. Codes (required, if applicable)
Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded.

Item 76 — Adm. Diag. Cd.
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Item 77 — E-Code (not required)

Item 78 — Unlabeled Field (reserved for state use)

Item 79 — P.C. (not required)

Item 80 — Principal Procedure Codes and Dates (required, if applicable)
Enter the ICD-9-CM surgical procedure code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Note: Most often the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

Item 81 — Other Procedure Codes and Dates (required, if applicable)
If more than six procedures are performed, report those that are most important for the episode using the same guidelines for determining principal procedure (Item 80).

Item 82 a-b — Attending Phys. ID
Enter the Unique Physician Identification Number or license number and name.

Item 83 a-b — Other Phys. ID (not required)

Item 84 a-d — Remarks (enter information when applicable)
Enter third-party insurance (commercial insurance coverage) unless the service does not require third-party billing. Third-party insurance must be billed before billing Wisconsin Medicaid.

Other Insured's Name
Providers must bill commercial health insurance before billing Wisconsin Medicaid unless the service does not require health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook. Leave this item blank when the following applies:

- The provider has not billed the commercial health insurance because eligibility verification did not indicate other coverage.
- The service does not require commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook.
- Eligibility verification indicates "DEN" only.
- When eligibility verification indicates "HPP," "BLU," "WPS," "CHA," or "OTH," and the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, indicate one of the following codes:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the recipient's health insurance pays any portion. The claim indicates the amount paid by the health insurance company to the provider or the insured.
OI-D	Use the OI-D disclaimer code only when these three criteria are met: √ Eligibility verification indicates "HPP," "BLU," "WPS," "CHA," "DEN," or "OTH." √ The service requires billing health insurance before Wisconsin Medicaid. √ The charges have been billed to the health insurance company and the insurance company has denied them.
OI-Y	Use the OI-Y disclaimer code when the identification card indicates other coverage but the insurance company was not billed for reasons including: √ The provider knows the service in question is not covered by the insurer (i.e., has a previous denial). √ Insurance failed to respond to a follow-up claim.

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When eligibility verification indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated, if applicable:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays any portion. The amount paid is indicated on the claim.
OI-H	Use the OI-H disclaimer code only when these two criteria are met: √ Eligibility verification indicates "HMO" or "HMP." √ The HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance or deductible amount.
Note:	Providers may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not reimburse services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Appendix 9
(Continued)

Medicare must be billed before Wisconsin Medicaid. Indicate a Medicare disclaimer code if both the following statements are true:

- Medicare covers the procedure at least sometimes.
- The recipient's Wisconsin Medicaid eligibility verification shows he or she has Medicare coverage for the service performed. For example, the service is covered by Medicare Part A and the recipient has Medicare Part A.
- The nonphysician provider's Wisconsin Medicaid file shows he or she is Medicare certified. (If necessary, Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.

Code *Description*

M-1 Medicare benefits exhausted. Use this code when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 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 performed 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 procedure provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

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M-5 Provider is not Medicare-certified. Use this code when the provider is identified in Wisconsin Medicaid files as being Medicare certified but the provider is billing for dates of service before or after his or her 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 not certified for Medicare Part A.
- 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 not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6 Recipient not Medicare-eligible. Use this code when Medicare denies payment for services related to chronic renal failure because the recipient is not eligible for Medicare. Bill Medicare first even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare.

Use M-6 in these two instances only:

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

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

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

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

M-7 Medicare disallowed or denied payment. Use this code 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.

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.

M-8 Noncovered Medicare service. Use this code when Medicare was not billed because the service, under certain circumstances (for example, diagnosis), is not covered.

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 (for example, diagnosis).

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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 (for example, diagnosis).

Leave the element blank if Medicare is not billed because eligibility verification indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefits to the claim and leave this element blank. Do not enter Medicare paid amounts on the claim form. Refer to the Claims Submission section of the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Item 85 — Provider Representative

Enter an authorized signature indicating that the information entered on the face of this claim is in conformance with the certification on the back of this claim. A facsimile signature is acceptable.

Item 86 — Date

Enter the date on which the claim is submitted to the payer.

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Appendix 10
Sample UB-92 Claim Form for Inpatient Services

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL
327 HOSPITAL RD
ANYTOWN WI 55555
(555) 327-5555

2: 111111111

3 PATIENT CONTROL NO.: 123456789

4 TYPE OF BILL: 111

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 080901 THROUGH: 081401

7 COV D.: 5 | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: RECIPIENT, IMA D.

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24–30 CONDITION CODES	31
09251975	F		080901	07	1		1	7	03 7654321		

32 OCCURRENCE CODE / DATE | 33 | 34 OCCURRENCE CODE / DATE | 35 | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38 | 39 VALUE CODES CODE / AMOUNT | 40 | 41 VALUE CODES CODE / AMOUNT

Line	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	ROOM — BOARD/SEMI			5	1512 60		
2	250	PHARMACY			19	243 95		
3	271	SUPPLY/NON-STER			19	65 32		
4	272	STERILE SUPPLY			8	179 44		
5	300	LABORATORY/LAB			6	513 80		
6	305	LAB/HEMATOLOGY			1	62 00		
7	324	DX X-RAY/CHEST			1	124 75		
8	350	CT SCAN			1	470 72		
9	420	PHYSICAL THERP			5	341 85		
10	424	PHYS THERP/EVAL			1	142 87		
11	450	EMERG ROOM			3	637 13		
12	730	EKG/ECG			1	132 00		
21	001	TOTAL				4426 43		

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50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
T19 — WI Medicaid	87654321					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
		1234567890		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
1234567			

67 PRIN. DIAG. CD.	68 CODE	69	70 CODE	71	72 CODE	73	74 CODE	75	76 ADM. DIAG. CD.	77 E-CODE	78
9661	78039	43889	72989	7813	43820	43811			9661	E8550	

79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID: N24680 PHYSIESON

83 OTHER PHYS. ID: 11111

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X I.M. Provider

86 DATE: 081901

UB-92 HCFA-1450 | OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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Appendix 11
Wisconsin Medicaid Newborn Report
(for photocopying)

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(A copy of the Wisconsin Medicaid Newborn Report is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1165 (Rev. 02/03)

WISCONSIN MEDICAID
NEWBORN 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, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

INSTRUCTIONS

1. Type or print clearly.
2. All requested information must be provided.
3. In multiple birth situations, a separate Newborn Report must be filled out for each birth.
4. For more information on newborn reporting, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883. Mail or fax completed forms to:

   Wisconsin Medicaid
   PO Box 6470
   Madison WI 53716
   Fax (608) 224-6318

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SECTION I — HOSPITAL (OR OTHER PROVIDER) INFORMATION

Name — Hospital (or Other Provider)	Wisconsin Medicaid Provider Number (eight digits)
Name — Contact Person	Telephone Number — Contact Person ( )

SECTION II — NEWBORN INFORMATION

Name — Newborn (First, Middle Initial, Last)	Date of Birth (MM/DD/YYYY)
Sex ❑ Female ❑ Male	Date of Death, if applicable (MM/DD/YYYY)
Multiple Births ❑ Yes ❑ No If yes, complete a form for each birth.	

SECTION III — MOTHER INFORMATION

Name — Mother	Address (Street, City, State, and Zip Code)
Medicaid Identification Number — Mother	
Medicaid Identification Number — Case Head	

SECTION IV — AUTHORIZATION

This information is accurate to the best of my knowledge.

SIGNATURE — Hospital (or Other Provider) Representative	Date Signed

Appendix 12
Revenue Codes for Hospitals

The following is a complete list of Medicaid-allowable revenue codes for inpatient and outpatient hospital claims.

Policy	Specific Revenue Codes
Revenue codes that require a service-specific third digit from the UB-92 Billing Manual	11X, 12X, 13X, 15X, 16X, 17X, 20X, 21X, 25X, 36X, 51X, 71X, 90X, 91X, 92X, 94X, 96X
Revenue codes that require a *Current Procedural Terminology* laboratory procedure code for outpatient services	30X, 31X, 923, 925
Revenue codes for dental services	512 (Use when providing dental services as part of an outpatient visit.)
Revenue codes for vision care services	519 (Use when providing vision care services as part of an outpatient visit.)
Outpatient observation room	719 (Use when recipient is under observation after recovering from ambulatory surgery.)
Revenue codes exempt from recipient copayment	820-859, 901, 918 *Note:* Revenue code 253 is exempt from recipient copayment on crossover claims. Revenue code 450 is exempt from copayment for outpatient services.
Noncovered revenue codes	140-149, 180-189, 220-221, 229, 294, 374, 547-548, 550, 609, 624, 637, 660-669, 670-679, 780-789, 880, 990-999
Noncovered revenue codes for psychiatric hospitals	520, 529, 940, 949
Noncovered revenue codes for general hospitals billing psychiatric or substance abuse services	520, 529, 940, 949
Nonbillable revenue codes	Nonbillable for bill type 11X: 100-101, 115, 135, 155, 240, 249, 253, 259, 279, 291-293, 299, 479, 530-531, 539, 540-546, 549, 551-552, 559, 570-572, 579, 580-582, 589, 590, 599, 600-604, 650-657, 659, 912-913, 960-964, 969, 971-979, 981-989 Nonbillable for bill type 13X: 180-239, 240, 249, 259, 279, 299, 540-546, 549, 550-552, 559, 570-572, 579, 580-582, 589, 590, 599, 600-604, 650-657, 659, 912-913, 990-999
Billable, noncovered revenue code	180
Restricted revenue codes	110-114, 116-117, 119
Revenue code for medication checks	510

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Appendix 13
Wisconsin Medicaid Organ Transplant Institutions

The following is a partial list of Wisconsin Medicaid-allowable organ transplant institutions.

Type of Transplant	Facility
Bone-marrow	May be done at any Wisconsin Medicaid-approved facilities
Heart	• Abbott Northwestern Hospital — Chicago, IL. • Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • Mayo Clinic (St. Mary's Hospital) — Rochester, MN. • St. Luke's Medical Center — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Heart-lung	• Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • St. Luke's Medical Center — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Kidney	May be done at any Medicare-approved facility.
Liver	• Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • St. Luke's Medical Center — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Lung	• Children's Hospital of Wisconsin — Milwaukee, WI. • Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.
Pancreas	• Fairview University Medical Center (University of Minnesota Hospital and Clinics) — Minneapolis, MN. • Froedtert Memorial Lutheran Hospital — Milwaukee, WI. • University of Wisconsin Hospital and Clinics — Madison, WI. • Other out-of-state hospitals approved by Medicare.

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Appendix 14
Inpatient Dual-Entitlee Billing Instructions for Partial or No Part A Benefits

Use the following billing instructions for dual-entitlees with partial or no Medicare Part A benefits.

Part A Benefits Exhausted Prior to Admission (No Part A)

1. Bill Medicare for all Medicare Part B billable ancillaries for the noncovered Medicare Part A days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the crossover claim (automatic or paper submission — CT 31 — Outpatient Crossover).
2. Bill Wisconsin Medicaid for all inpatient charges including the Medicare Part B charges. In Items 39 to 41 of the UB-92 claim form use the value code 81 and state the total charges billed to Medicare Part B (not the Medicare payment amount). In Item 84 of the UB-92 claim form indicate Medicare disclaimer code "M-1." Wisconsin Medicaid pays the claim (CT 40 — straight Wisconsin Medicaid Inpatient) deducting the amount shown with value code 81 from the diagnosis related group (DRG) reimbursement since this amount was already paid through the crossover claim (CT — 31 Outpatient Crossover). Do not attach the Medicare Remittance Advice (RA) to this claim.
3. (Optional) Bill Medicare for the Professional Component charges on the CMS 1500 claim form. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the crossover claim (automatic or paper submission — CT 30 — Professional Crossover).

Part A Benefits Exhausted Mid-Stay (Partial Part A)

1. Bill Medicare for all charges for the entire stay. Medicare approves and pays the Medicare Part A covered days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved days through the crossover claim (automatic or paper submission — CT 50 — Inpatient Crossover).
2. Bill Medicare for all Medicare Part B billable ancillaries for the noncovered Medicare Part A days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the crossover claim (automatic or paper submission — CT 31 — Outpatient Crossover).
3. Bill Wisconsin Medicaid for all inpatient charges for the entire stay, including the Medicare Part B charges. In Items 39 to 41 of the UB-92 claim form, use both value codes 81 and 83.

   With value code 81, state the total charges billed to Medicare Part B (not Medicare Payment Amount).

   With Value code 83 state the Medicare Part A allowed amount. The Medicare Part A allowed amount is calculated from the Medicare RA by adding the Medicare paid amount, plus both the coinsurance amount and deductible amount. The total of these amounts must be listed in value code 83.

   In Item 84 of the UB-92 claim form, indicate Medicare disclaimer code "M-1."

   Wisconsin Medicaid pays the claim (CT 40 — straight Medicaid Inpatient) deducting the total amounts shown with value codes 81 and 83 from the DRG reimbursement since these amounts were already paid through the crossover claims (CT 31 — Outpatient Crossover and CT 50 — Inpatient Crossover).

   Do not attach the Medicare RA to this claim.

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Glossary of Common Terms

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

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

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

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

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BQA
Bureau of Quality Assurance. The BQA surveys hospital facilities to ensure they meet strict fire and life safety codes, and administrative and program standards specifically required for hospitals by the Department of Health and Family Services (DHFS).

CLIA
Clinical Laboratory Improvement Act. Congress implemented CLIA to improve the quality and safety of laboratory services. CLIA establishes standards and enforcement procedures.

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

CON
Certification of Need. Federal and state regulations require providers to conduct and document a CON assessment for all recipients under the age of 21 who are admitted to a psychiatric or substance abuse institution for mental disease (IMD) for elective/urgent or emergency psychiatric or substance abuse (alcohol and other drug abuse) treatment services.

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 sent 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
Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. 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.

DRG
Diagnosis-related group. Wisconsin Medicaid's payment system for hospitals.

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.

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Emergency services
Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB
Explanation of Benefits. Appears on the providers Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

ERO
External Review Organization. The ERO, under contract with the Department of Health and Family Services (DHFS), reviews the quality and utilization of inpatient hospital services provided to Medicaid recipients.

EVS
Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).
- Wisconsin Medicaid's Provider Services (telephone correspondents).

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 Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA
Health Care Financing Administration. *Please refer to the definition under CMS.*

HCPCS
Healthcare 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. Formerly known as HCFA Common Procedure Coding System.

HealthCheck
A 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.

IMD
Institution for Mental Disease. Wisconsin Medicaid certifies hospitals as IMDs in accordance with HFS 105.21, Wis. Admin. Code, and based on the hospital's eligibility for certification with Medicare or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Inpatient
A recipient who is admitted to the hospital as an inpatient and is counted in the midnight census.

Maximum allowable fee schedule
A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

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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 Medicaid 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.

Outpatient
A recipient who has not been officially admitted to the hospital as an inpatient and has not been counted in the midnight census.

PA
Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

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

R/S Report
Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

State Plan
Wisconsin Medicaid's federally approved description of methods and standards for establishing payment rates to hospitals.

Swing Bed Services
Rural hospitals with fewer than 100 beds can receive approval from the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, for beds to be used interchangeably as hospital and skilled nursing facility beds. The days on which these beds are used as skilled nursing facility beds the patient days are considered swing bed services.

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

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