

Medical Assistance Provider Bulletin

Attention: All Title XIX
Certified Laboratories and
Portable X-ray Providers

Subject: New Claim Form;
Place of Service, Type of
Service and HCPCS Codes; and
New Prior Authorization
Request Form

Date: September 1, 1987

Code: MAPB-087-008-K

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This bulletin should be used in conjunction with the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987.

I. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) has signed a new fiscal agent contract with E.D.S. Federal Corporation (EDS). Under this new contract, there will be major enhancements in the processing of Medical Assistance claims received by EDS on or after January 1, 1988. These enhancements are discussed in detail in the above referenced All Provider Bulletin.

In addition to the changes resulting from the new contract with EDS, the Health Care Financing Administration (HCFA) has mandated that all State Medical Assistance agencies implement use of a new claim form, the National Health Insurance Claim Form, HCFA 1500. The WMAP is implementing use of the National HCFA 1500 claim form for most providers. Many providers already

use the Wisconsin version of the HCFA 1500 claim form to bill the WMAP and some are using the National HCFA 1500 claim form to bill Medicare and other third party payors. To facilitate consistent billing procedures, the WMAP is implementing the National HCFA 1500 claim form and national and local Place of Service and Type of Service codes.

Concurrent with the claim form change, the WMAP is also implementing the HCFA Common Procedure Coding System (HCPCS) currently used by Medicare. Use of HCPCS codes is also federally mandated.

NOTE: Due to the above mentioned changes, EDS will be converting the claims processing system at the end of 1987. Providers are advised to submit to EDS for receipt by no later than December 24, 1987, all claims, adjustments and prior authorization requests which are completed in accordance with billing instructions and claim forms in use in 1987. EDS will return, unprocessed, any claims received after December 24 which are in the 1987 format.

Past experience has shown that delivery of claims mailed during the holiday season is delayed due to heavy holiday mail. Please allow ample mailing time to ensure that claims mailed in 1987 are received no later than December 24. If there is a likely possibility that claims prepared and mailed in late December will not be received by EDS by December 24, it may be to the provider's advantage to hold such claims and mail them in the new format on or after January 1, 1988.

Providers are also advised that no checks will be issued on January 3, 1988. Claims which would have finalized processing during that week will appear on the following week's Remittance and Status Report.

II. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500

All Laboratory and Portable X-ray providers are required to use the National HCFA 1500 claim form for all claims received by EDS on or after January 1, 1988. Claims, including resubmission of any previously denied claims, received on a form other than the National HCFA 1500 claim form will be denied by EDS. Modifications to or use of modified versions of the National HCFA 1500 claim form may also result in claims denial.

Detailed billing instructions are included in Attachment 2 of this bulletin. Sample claim forms for Independent Laboratory services and Portable X-ray services are included in Attachments 1a and 1b. Effective January 1, 1988, these instructions should be used to replace those currently included in the Laboratories, X-ray and Radiology Provider Handbook, Part G, issued in March, 1981.

Providers should pay special attention to the following areas on the National HCFA 1500 claim form itself and to the changes in the type of information required for completion of the claim form.

1. Program Block (Claim Sort Indicator). A new element, the claim sort indicator, must be entered in the program block for Medicaid which is located on the top line of the claim form. This indicator identifies the general kinds of services being billed and is essential to processing of the claim form by EDS. Claim sort indicators for each type of service are included in the billing instructions. The sample claim forms included in Attachments 1a and 1b indicate where on the claim form this information is to be entered. Claims received on or after January 1, 1988 without this claim sort indicator will be denied.
2. Element 1. The recipient's last name is required first, then the first name, and middle initial.
3. Element 6. The 10 digit Medical Assistance Recipient Identification Number must be entered.
4. Element 9. Revised "Other Insurance" (OI) disclaimer codes, identified in the claim form completion instructions, must be entered in this element.
5. Element 10. This is an addition to the element which requests "other" accident information.
6. Element 11. Medicare disclaimer codes, identified in the claim form completion instructions, must be entered in this element.
7. Element 24. There are two (2) fewer line items than on the current HCFA 1500 claim form.
8. Element 24H. Recipient spenddown amount, when applicable, must be entered in this element.

Providers should reference the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987, for additional details on billing and claims processing changes.

Effective January 1, 1988, the National HCFA 1500 claim form will not be provided by either the WMAP or EDS. It is a national form that can be obtained at the provider's expense from a number of form printers and other sources. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
MADISON WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (Toll free)

III. PLACE OF SERVICE CODES

Claims received by EDS on or after January 1, 1988 must include national place of service (POS) codes in element #24B on the National HCFA 1500 claim form. Claims/adjustments submitted without POS codes or with incorrect POS codes will be denied. POS codes are listed on the back of the claim form. Allowable POS codes for Independent Laboratory and Portable X-ray providers are included in Attachment 5.

IV. TYPE OF SERVICE CODES

Effective January 1, 1988, the WMAP is converting currently used type of service (TOS) codes to coincide with the National TOS codes, which are located on the back of the National HCFA 1500 claim form, and with the additional codes used by Medicare and the WMAP. All providers are required to indicate the appropriate TOS code in element 24G on the claim form for each line item billed on all claims received on or after January 1, 1988. Claims/adjustments submitted without TOS codes will be denied. Claims/adjustments submitted with incorrect TOS codes are subject to incorrect reimbursement or denial. Allowable TOS codes for Independent Laboratory and Portable X-ray providers are included in Attachment 5.

V. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

The Health Care Financing Administration has also mandated state Medical Assistance agencies to use HCPCS. HCPCS is a procedure coding system that is currently used by Medicare.

HCPCS codes are composed of:

- Physician's Current Procedural Terminology - Fourth Edition (CPT-4) codes which are updated annually;
- Nationally assigned codes which are five (5) characters in length (alpha/numeric) and begin with any of the alpha characters A through V, e.g., A1234 - V5678; and
- Codes locally assigned by the WMAP or the Medicare Intermediary which are five (5) characters in length (alpha/numeric), and begin with the alpha characters W through Z, e.g., W1111 - Z9999.

HCPCS codes and their narrative descriptions are required on all claims/adjustments received by EDS on or after January 1, 1988. Claims/adjustments submitted without HCPCS codes and narrative descriptions will be denied. Allowable HCPCS codes and their descriptions for Independent Laboratory services are listed in Attachment 3. Allowable HCPCS codes for Portable X-ray services are included in Attachment 4.

ATTACHMENTS
INDEPENDENT LABORATORY AND PORTABLE X-RAY SERVICES

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**ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR PORTABLE X-RAY & INDEPENDENT LAB SERVICES**

To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the information in the Patient and Insured (subscriber) Information section.

Program Block/Claim Sort Indicator

Enter the appropriate CLAIM SORT INDICATOR for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

- 'D' - Corrective Shoes
 - Durable Medical Equipment (unless dispensed by a therapist)
 - Hearing Aids
- 'M' - Independent Nurse
 - Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
 - Nurse Midwife
 - Rehabilitation Agency
 - Community Care Organizations
- 'P' - Chiropractor
 - Family Planning
 - Free Standing Ambulatory Surgery Center

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- 'P' - Independent Laboratory and Portable X-Ray
 - Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
 - Physician
 - Rural Health Agency

- 'T' - Therapy - Occupational, Physical, Speech and Hearing
 - Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

- 'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME

Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH

Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME

If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank. When billing for a newborn, enter the mother's last name, first name, middle initial and date of birth in MM/DD/YY format.

ELEMENT 4 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

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ELEMENT 5 - PATIENT'S SEX

Specify if male or female with an 'X'.

ELEMENT 6 - INSURED'S ID NUMBER

Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE

Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of

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the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO

If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS

This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

ELEMENTS 12 - 13

(Not required, provider automatically accepts assignment through medical assistance certification.)

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ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY

Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN

Enter the referring/ prescribing physician's name and eight digit medical assistance number, if available.

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY

If the services billed were performed at a facility other than the recipient's home or the provider's office (i.e., nursing home or hospital), enter the name, address and, if available, the eight digit medical assistance provider number.

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS

The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or

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condition related to the services provided. List the primary diagnosis first. Etiology ('E') codes may not be used as a primary diagnosis.

ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER

EPSDT

If the services were performed as a result of an EPSDT/HealthCheck referral, check 'YES'; otherwise check 'NO'. EPSDT/HealthCheck indicators may not be left blank; a positive or negative response must be indicated.

Family Planning

If the recipient is receiving family planning services only, enter an 'X' in 'YES'. If none of the services are related to family planning, enter an 'X' in 'NO'.

NOTE: If the services reported are a combination of family planning services and services related to other diagnoses, the family planning indicators must be left blank.

To ensure accurate reporting of family planning services (enabling the State to receive Federal Financial Participation monies), the Diagnosis Code Reference must be utilized. Please refer to 'Diagnosis Code Reference' - element 24D for detailed instructions on the use of this claim form element.

Prior Authorization

The seven digit prior authorization number from the approved prior authorization form must be entered in element 23B. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claims.

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ELEMENT 24 - SERVICES

Element 24A - Date of Service

In column A, enter the month, day and year in MMDDYY format for each procedure. It is allowable to enter up to four dates of service per line item for each procedure if:

- * All dates of service are in the same calendar month.
- * All procedures performed are identical.
- * All procedures were performed by the same provider.
- * The place and type of service is identical for all procedures.
- * The same diagnosis is applicable for each procedure.
- * The charge for all procedures is identical. (Enter the charge per service following the description in element 24C.)
- * The number of services performed on each date of service is identical.

Element 24B - Place of Service

Enter the appropriate place of service code in column B for each service. Refer to Attachment 5 of this bulletin for a list of allowable place of service codes for independent laboratories and portable x-ray providers.

Element 24C - Procedure Code and Description

Enter the appropriate procedure code, modifier and matching description for each service performed. Enter a written description which is concise, complete and specific for each billed service.

Beneath the description of service, enter the name and eight digit provider number of the performing provider if different than the billing provider indicated in element 31.

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Element 24D - Diagnosis Code Reference

When multiple procedures/diagnoses are submitted, column D must be utilized to relate the procedure performed (element 24C) to a specific diagnosis in element 23A.

The diagnosis code itself may be entered in column D, or enter the line number from element 23A (i.e., 1, 2, 3 or 4) of the appropriate diagnosis as shown on the claim example.

Element 24E - Charges

Enter the total charge for each line item.

Element 24F - Days or Units

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

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment 5 of this bulletin for a list of allowable type of service codes for independent laboratories and portable x-ray providers.

Element 24H - Recipient Spenddown

Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE

The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

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ELEMENT 26 -

(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 27 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00.

ELEMENT 29 - BALANCE DUE

Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

ELEMENT 31 - PROVIDER NAME AND ID NUMBER

Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number. If the provider number indicated in element 31 is not the actual provider of service, the performing provider's number must be entered beneath the description of service in element 24C.

ELEMENT 32 - PATIENT ACCOUNT NUMBER

Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)

ATTACHMENT 3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR INDEPENDENT LAB SERVICES

The new HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
08561	P9000	n/a	Visit to Nursing Home for the Purpose of Drawing Blood Specimen for a Single Patient	n/a
08562	P9001	n/a	Visit to Nursing Home for the Purpose of Drawing Blood Specimens for Multiple Patients	n/a
08563	P9000	Z1	Out-of-Zone Pick Up, single patient	n/a
08564	P9001	Z2	Out-of-Zone Pick Up, multiple patients	n/a

ATTACHMENT 4

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
 FOR PORTABLE X-RAY SERVICES

The new HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
07468	R0070	n/a	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen	n/a
07469	R0075	n/a	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, per patient	n/a
07473	R0075	Z2	X-ray Out-of-Zone Pick Up, multiple patients	n/a
07479	R0070	Z1	X-ray Out-of-Zone Pick Up, single patient	n/a
07468	W0585	n/a	Transportation of portable EKG equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, per patient	n/a
07469	W0590	n/a	Transportation of portable EKG equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, per patient	n/a

ATTACHMENT 5

PORTABLE X-RAY & INDEPENDENT LAB SERVICES

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
2	4	Home
4	7	Nursing Home
4	8	Skilled Nursing Facility
6	A	Independent Lab

TYPE OF SERVICE (TOS) CONVERSION TABLE

Providers of portable x-ray and independent lab services are required to indicate one of the following type of service codes in element 24G of the National HCFA 1500 claim form.

Prior to 01/01/88	Effective 01/01/88	New Description
5	5	Diagnostic Lab (total) (includes EKG)
4	4	Diagnostic X-ray (total)
N	U	Diagnostic X-ray (technical component)
S	B	Diagnostic Medical (total) (includes EKG)