Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Providers

Subject: Legislative Update and Other Information

Date: December 21, 1987

Code: MAPB-087-038-X

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This bulletin contains important information on the following:

Wisconsin Department of Health and Social Services, Division of Health, Bureau of Health Care Financing, Provider/Recipient Services, P.O. Box 309, Madison, Wisconsin 53701

I. INTRODUCTION

With passage of the State 1987-89 Budget Bill, and new Federal legislation, a number of changes to the Wisconsin Medical Assistance Program (WMAP) are being implemented and are discussed in this bulletin. In addition, this bulletin contains other important information and updates on WMAP policies, including corrected billing instructions for specific provider types. All providers should review this bulletin very carefully. Those provider types identified in Section XVIII, Correction and Clarification of Billing Instructions Included in Previous Provider Bulletins, should pay special attention to the billing instructions discussed in that section, and make the appropriate changes to instructions included in previously issued provider bulletins.

II. CHANGES AFFECTING SUPPLEMENTAL SECURITY INCOME RECIPIENTS RESIDING IN WISCONSIN MEDICAL ASSISTANCE CERTIFIED NURSING HOMES

In the past, Supplemental Security Income (SSI) recipients residing throughout the month in Medical Assistance (MA) certified nursing homes have had their SSI benefits limited to $25 per month.

Section 3 of Public Law 99-643 (the Employment Opportunities for Disabled Americans Act), which is effective July 1, 1987, allows certain recipients of SSI benefits to receive full SSI benefits for the first two complete months of institutionalization when in a WMAP certified nursing home. These recipients are known as 1619(a) and (b) cases.

WMAP certified nursing homes are not to count the SSI benefits for 1619(a) and (b) case recipients towards the cost of care for the first two complete months in the nursing home. Providers with questions regarding this provision of the law should contact the local county or tribal social services agency, or the local Social Security office. The local Social Security office will inform nursing homes of the 1619(a) and (b) cases receiving two months of full SSI benefits.

III. EXPANDED BENEFITS FOR PREGNANT WOMEN AND CHILDREN

A. Increase in Medically Needy Income Eligibility Limits

The income eligibility limits for WMAP coverage to Medically Needy recipients have been raised. As a result, providers may see more pregnant women and recipients under age 18 who will present "medically needy" WMAP recipient identification cards for care.

B. New MA Eligibility for Pregnant Women

The Federal Consolidated Omnibus Budget Reconciliation Act requires the WMAP to now provide MA coverage to any pregnant woman with family income at or below the WMAP income limits. This expansion of coverage will increase the number of pregnant women presenting medical assistance identification cards for care. In addition, any pregnant woman eligible under this provision whose pregnancy ends while a WMAP recipient will continue to be eligible for MA benefits for the 60 days immediately following the pregnancy.

C. Presumptive Eligibility

The State legislature has enacted into law a program known as "presumptive eligibility." The purpose of presumptive eligibility is to begin WMAP prenatal care coverage to low income pregnant women as early in their pregnancy as possible. This program will enable any pregnant women with reported incomes at or below the WMAP limit, and with a verified pregnancy, to receive WMAP reimbursable ambulatory prenatal care before they apply for and receive their regular MA recipient identification card. Certain WMAP providers who meet the federal presumptive eligibility requirements of a "qualified provider," and who sign an agreement with the WMAP, will be able to issue temporary "presumptive eligibility" MA recipient identification cards to pregnant women. In order to become a "qualified provider" under the presumptive eligibility program, providers must meet the following requirements:

1. Be a certified provider in the WMAP; and

2. Provide services of the type provided by:

   a. Outpatient hospitals, or
   b. Rural health clinics, or
   c. Clinics furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician; and

3. Be specifically designated by the WMAP, in writing, as a qualified provider for the purpose of determining presumptive eligibility based on family income; and

4. Meet one of the following:

   a. Receive funds under:

      1) The Migrant Health Centers or Community Health Centers (of the Public Health Service Act); or

      2) The Maternal and Child Health Services Block Grant Programs; or

   b. Participate in the program established under:

      1) The Special Supplemental Food Program for Women, Infants and Children (WIC); or

      2) The Commodity Supplemental Food Program of the Agriculture and Consumer Protection Act of 1973; or

   c. Participate in a State perinatal program.

The "presumptive eligibility" MA recipient identification card will indicate "Outpatient Services Only." The card will allow the presumptively eligible recipient to receive WMAP reimbursable ambulatory prenatal care, which includes services related to the pregnancy and conditions that may complicate the pregnancy, only from "Qualified Providers" who have signed agreements with the WMAP. The MA recipient identification card will be valid for 14 calendar days, but may be extended to 45 days if the recipient makes application for medical assistance at the local certifying agency (county or tribal human or social services agency) before the end of the initial 14 day period. Presumptive eligibility will continue until a formal decision is made on the recipient's MA eligibility status, or the 45 day period ends, whichever occurs first.

Qualified providers may be reimbursed by the WMAP for ambulatory prenatal care provided to presumptively eligible pregnant women independent of certification or denial of MA eligibility by the certifying agency. Providers should review the temporary MA recipient ID card carefully to identify presumptively eligible recipients. The card indicates the dates of eligibility and will be valid only for ambulatory prenatal care from a Qualified Provider.

Potential providers will be contacted by the Bureau of Health Care Financing with more detailed information about presumptive eligibility and becoming "Qualified Providers."

IV. CASE MANAGEMENT

Effective October 1, 1987, the WMAP program covers case management services for MA recipients who reside in counties where the local county government has elected to participate in this service. Case management is defined as the coordination of medical, psychological, social, vocational and rehabilitative needs of an MA recipient. Recipients who are eligible for case management services are:

1. Persons age 65 or older;
2. Those with Alzheimer's disease;
3. The developmentally disabled;
4. The chronically mentally ill (age 21 and older);
5. The alcohol or drug dependent;
6. The physically or sensory disabled; and
7. Severely emotionally disturbed children (under age 21).

WMAP coverage of case management services is not available for persons enrolled in HMOs, or who are participating in WMAP home and community based waivers.

Only agencies which are the direct recipients of state general purpose revenue (GPR) funded programs, e.g., "Community Aids", can be WMAP-certified, since no new non-federal matching dollars were approved by the Legislature. Potentially certifiable providers have been notified and certification is underway.

V. SPECIALIZED INPATIENT TREATMENT FOR MENTAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE PROBLEMS: RESTRICTIONS ON MEDICAL ASSISTANCE COVERAGE

Federal law does now allow federal matching funds to be claimed for care in an "Institution for Mental Diseases" (IMD) for MA recipients aged 21 through 64. As a result, the WMAP does not pay for care at the state mental health institutions (Mendota and Winnebago) for persons age 21 through 64; nor does it pay for care for recipients of these ages when they are admitted to a special psychiatric hospital.

The WMAP has been informed by the Federal government that other types of facilities may also be considered as IMDs. Specifically, federal guidelines issued effective for dates of service on and after October 1, 1986 specify that general hospitals that specialize in caring for persons who abuse alcohol and other drugs (AODA), or who have other mental health problems, may also be found to be IMDs. Because of this federal guideline, the WMAP no longer pays such facilities for care provided to recipients ages 21 through 64 for dates of service on and after October 1, 1987. Instead, county mental health boards are responsible for assisting recipients in obtaining specialized inpatient AODA and mental health care to the extent that the county mental health board's funds allow. This provision does not affect WMAP coverage of AODA care

in special units of general hospitals, as long as that facility is not considered to be an IMD, (i.e., the majority of care that the hospital provides is medical-surgical).

VI. COPAYMENTS

The following includes general information on copayment exemptions:

A. Copayment Exemptions

Providers are reminded of the following copayment exemptions:

1. Emergency services;
2. Services provided to nursing home residents;
3. Services provided to recipients under 18 years of age;
4. Services provided to a pregnant woman if the services are related to the pregnancy;
5. Family planning services; and
6. Services provided through Health Maintenance Organizations (HMOs) to enrollees of the HMO.

B. New Copayment for Physician Services

Effective for dates of service on and after January 1, 1988, the following copayments will apply to the following physician services:

1. Physician Visits

A $1.00 copayment per service is required for all physician visits identified by the following HCPCS (CPT-4) procedure codes:

Procedure Code	Type of Service	Description
90000 - 90080	1	Office Visits
90100 - 90170	1	Home Visits
90200 - 90220	1	Inpatient Hospital Visits
90240 - 90280	1	
90500 - 90580	1	Outpatient Hospital Visits
90600 - 90654	3	Consultations
92002 - 92014	1	Eye Examinations
92081 - 92083	1	
92225 - 92226	1	

The current copayment limitation which exempts more than 6 physician visits from copayment is eliminated effective for dates of service on and after January 1, 1988. It is replaced by a $30.00 cumulative limit per calendar year, per recipient per physician for all physician services, (specifically, physician visits, surgery, lab and x-ray services, and diagnostic tests).

2. Surgery Services

A $3.00 copayment per service will apply to all HCPCS (CPT-4) surgery procedure codes 10000 - 69999 (except 57160, 57170, 57291, 57292, 57400, 57700, 58100, 58101, 58102, 58103, 58300, 58301, 58320-58350, 58600-58615, 58750-58760, 58900-58920, 58982-58995, and 59000 - 59899 which represent surgical procedures relating to pregnancy and family planning). Surgical assists and anesthesia are not subject to copayment.

3. Laboratory Services

A $.50 copayment per service is required for all HCPCS (CPT-4) laboratory procedure codes 80000 - 89999 (type of service 5), except codes 80055, 84702, 84703, and 86006 - 86009, performed in the physician's office. Laboratory services provided by an independent laboratory are exempt from copayment. The copayment will not apply to professional components of laboratory services (type of service X).

4. Radiology Services

A $1.00 copayment per service is required for all HCPCS (CPT-4) radiology procedure codes 70000 - 76999 (type of service 4) and 78000 - 79999 (type of service K) provided in the physician's office. Procedure codes 74710 - 74775, 76805 - 76825, and 77261 - 77799 are exempt. The copayment does not apply to separately billed professional or technical components of radiology services (types of service Q, S, T, U).

5. Diagnostic Tests

A $.50 copayment per service is required for the following HCPCS (CPT) procedure codes for medical diagnostic tests provided in a physician's office.

91000 - 91299	
92081 - 92083	
92225 - 92287	
92512 - 92589	
93000 - 93320	
93600 - 93618	
93720 - 93960	
94010 - 94620	
94680 - 94799	
95819 - 95999	(Type of Service B professional and technical component)

The copayment will not apply to separately billed professional or technical components of medical diagnostic test services (types of service U, W).

6. Copayment Limitation

No copayment may be assessed from any recipient for the physician services cited above in excess of $30.00 per calendar year per physician. This $30.00 copayment limit is a cumulative limit per calendar year, per physician, per recipient for all physician services referenced above. This means that a recipient is liable for a maximum of $30.00 copayment per year, per physician for any combination of these services. There is no separate copayment limit for each category of physician services.

7. Copayment Billing Procedure

Providers are reminded to bill the WMAP their usual and customary charges for all services rendered, including those subject to copayment. The amount of recipient liability, or "copayment", must be collected from recipients by providers, and is automatically deducted by EDS from payments allowed by the WMAP. Copayment amounts collected from recipients should not be deducted from charges billed to the WMAP, nor should these copayment amounts be indicated in the "paid by other" element on the claims submitted. Remittance and Status Reports from E.D.S. Federal Corporation (EDS) will reflect the automatic deduction of any applicable copayment amounts.

8. Instructions for Indicating Exempted Emergency Services on the Claim Form

Emergency services are exempt from copayment. Such services must be identified on the claim form by checking element #16a of the HCFA 1500 claim form and by coding modifier XE following the procedure code reflecting the emergency procedure code.

C. Increased Copayment for Outpatient Hospital Services

Effective for dates of service on and after January 1, 1988, the outpatient hospital copayment is increased to $3.00 per visit.

D. Elimination of Copayment for Hearing Aid Batteries

Effective for dates of service on and after January 1, 1988, copayment for hearing aid batteries is eliminated.

VII. LIMITATION ON PHYSICIAN VISITS FOR THE PURPOSE OF WEIGHT CONTROL OR WEIGHT REDUCTION

Effective for dates of service on and after January 1, 1988, prior authorization is required for more than five physician office visits to the same physician in a physician's office or an outpatient hospital, in a 12 month period, for the purpose of weight control or weight reduction. The WMAP will reimburse the first five such visits without prior authorization, provided that the visits are medically necessary. Visits in excess of five without prior authorization will be denied.

Providers must request prior authorization on the standard prior authorization cover form, form PA/RF, and the Physician Services Attachment, form PA/PA. Documentation for additional visits must include a copy of the dietetic evaluation and subsequent progress notes.

Food supplements, dietary supplies and vitamins provided as part of the physician visit are reimbursed in the payment for the visit and are not separately reimbursable.

VIII. CRITERIA FOR REIMBURSEMENT OF GASTRIC SURGERY FOR THE PURPOSE OF WEIGHT CONTROL PROVIDED DUE TO AN EMERGENCY CONDITION

Current Wisconsin Statutes allow reimbursement by the WMAP for gastric surgery for the purpose of weight control only where an emergency condition exists.

The State Medical Society Medicaid Medical Audit Committee, under a contract with the Department of Health and Social Services (DHSS), advises the WMAP that only rarely does an emergency situation occur with respect to the need for obesity-related gastric surgery. Acute cardiorespiratory failure, such as intractable CHF, pulmonary hypertension and nocturnal (supine) anoxemia with and without apnea resulting from or associated with gross obesity are presumed to be possibilities which might present an emergent situation warranting an operation of this type. The committee also feels that laboratory documentation (i.e., blood gases) of these clinical situations is mandatory to support reimbursement under the Statutes.

Gastric bypass surgery performed under emergency conditions may be performed without first obtaining prior authorization. However, claims submitted for such surgery must be supported by pertinent information, including a history and physical exam report and diagnostic values which document the emergency condition and the need for the surgery. Payment for gastric surgery for the purposes of weight control or reduction will be denied if the surgery is not performed as an emergency.

IX. SECOND SURGICAL OPINION PROGRAM (SSOP) UPDATE

The following are updates and reminders regarding the WMAP SSOP:

A. Procedure codes pertinent to cataract surgery requiring SSOP have changed. Providers are reminded that a second surgical opinion is required for cataract surgery HCPCS (CPT-4) codes 66983 and 66984.

These codes replace code 66980. Effective for dates of service on and after January 1, 1988, a second surgical opinion is no longer required for HCPCS (CPT-4) code 66985 (insertion of intraocular lens subsequent to cataract removal) because it does not represent cataract surgery.

B. Any physician licensed to practice in Wisconsin or in a border status state and certified by the WMAP may join the list of physicians providing second opinions to recipients in the WMAP. The SSOP especially needs additional SSOP physicians who specialize in ophthalmology and orthopedic surgery in the northern counties of Wisconsin. Physicians interested in participating should contact the:

Second Surgical Opinion Program
Center for Health Systems Research
and Analysis
1300 University Avenue
MADISON WI 53706
(608) 263-4459

C. Effective for dates of service on and after July 1, 1987, second surgical opinions obtained for the initial cataract and joint surgeries are valid indefinitely for surgery performed on the second eye or joint <u>if</u> the second opinion also included written documentation regarding the need for surgery of the second cataract or joint.

D. Providers are reminded <u>not</u> to arrange for their patient's second opinion appointments. This is the function of the SSOP. If there are special circumstances that require attention, providers should contact the SSOP office at (608) 263-4459.

X. UPDATE ON COVERAGE FOR ORGAN TRANSPLANTS

The WMAP does not pay for services or procedures which are considered to be experimental in nature. A procedure or service is considered experimental when the Department of Health and Social Services (DHSS) has determined that the procedure or service is not generally recognized by the professional medical community as effective or proven for the condition for which it is being used. A procedure or service may, however, be considered experimental in one setting or institution, but effective, proven and non-experimental in another, depending on the experience, quality and procedures used by a given institution.

The DHSS resolves questions relative to the experimental or non-experimental nature of a procedure based on the expert opinion of medical professionals. Under a contract with the DHSS, the Medicaid Medical Audit Committee of the State Medical Society performs such reviews including those of new and experimental services and technologies.

The process of reviewing and approving providers interested in providing these types of procedures assures that recipients receive expert care from only qualified institutions.

Based on recommendations of the Medicaid Medical Audit Committee, the DHSS currently allows reimbursement for heart, liver and pancreas transplantations only when appropriate and medically necessary, and when performed at approved institutions. Effective October 1, 1987, the DHSS accepted the Medicaid Medical Audit Committee's recommendation to approve reimbursement for heart transplants at St. Luke's Hospital, Milwaukee, WI; liver transplants (adults only) at Froedtert Memorial Hospital, Milwaukee, WI; and heart-lung transplants at the University of Wisconsin Hospital, Madison, WI. The revised list of institutions approved for Medical Assistance reimbursement of transplantation is included in Attachment C.

It is important that providers understand that transplants are reimbursed only at DHSS approved institutions and that recipients in need of such services be referred to these institutions only. This list of approved institutions will change over time. However, prior to making a referral to an approved transplant center, physicians should contact the facility to determine if the facility currently accepts WMAP patient referrals and Wisconsin Medical Assistance payment for the specific transplantation procedure required. Contact the WMAP Medical Consultant at (608) 266-2521 for answers to questions regarding WMAP covered transplants.

The DHSS does not currently allow reimbursement for any services directly or indirectly related to artificial heart implantation (temporary or permanent).

All major organ transplants (including bone marrow transplants) except kidney transplants, require prior authorization. The prior authorization request must be submitted jointly by the approved hospital involved and the transplant surgeon or physician involved, and must include appropriate written documentation attesting to the appropriateness of the proposed transplant. Prior authorization requests must be submitted to:

E.D.S. Federal Corporation
Attn: Prior Authorization - Suite 88
6406 Bridge Road
MADISON WI 53784-0088

Without prior authorization approval, payment will not be made for any services directly or indirectly related to the transplant. This includes services provided by the hospital, surgeon, assistant surgeon, anesthesiologist or any other physician(s).

XI. PHYSICIAN PRESCRIPTION REQUIREMENTS FOR SPECIALIZED MEDICAL VEHICLE (MSV) COT/STRETCHER SERVICES

Effective for all dates of service on or after January 1, 1988, specialized Medical Vehicle (SMVs) may be reimbursed for transport of recipients on a cot or stretcher only if no life support services are required during transport.

Claims which indicate that a patient was transported by an SMV on a cot or stretcher must also indicate on the claim that a prescription is on file from a physician prescribing this level of transportation. Physicians are advised that the prescription must include a statement saying that life support services were not required by the recipient during transport.

XII. EXPANDED COVERAGE FOR OVER-THE-COUNTER DRUGS

Effective for dates of service on and after January 1, 1988, the WMAP will provide coverage for over-the-counter (OTC) cough preparations and OTC ophthalmic lubricants.

Coverage for OTC cough preparations is limited to cough syrup - plain, cough syrup with dextromethorphan, and cough syrup with codeine.

Coverage of OTC ophthalmic lubricants is limited to products categorized as artificial tears. Coverage does not include eye drops or contact lens solutions.

Physicians are encouraged to prescribe these products as alternatives to more costly legend cough syrups and ophthalmic lubricants.

XIII. NEW REQUIREMENT FOR DRUG CLAIMS - DRUG ENFORCEMENT AGENCY (DEA) NUMBERS

All drug claims received on and after January 1, 1988, must indicate the prescribing provider's DEA number. The DEA number requirement is implemented to help the WMAP identify prescribing providers of WMAP drug services. This identifier will be used in claims processing, reporting and post payment review.

Physicians are advised that the WMAP has provided all pharmacies with a list of names and DEA numbers of all physicians and dentists certified by the WMAP. Incorrect DEA numbers must be corrected by the provider by writing to:

E.D.S. Federal Corporation
Attn: Provider Maintenance
6406 Bridge Road
MADISON WI 53784-006

XIV. SPECIALTY HOSPITAL BILLING AND PSYCHOTHERAPY LIMITS

Since 1986, the WMAP has counted all outpatient services provided by psychiatric specialty hospitals towards the $500/15 visit prior authorization limit for psychotherapy. The intent of this policy was to simplify the psychotherapy service accounting based on the assumption that all of the outpatient services offered by psychiatric hospitals were psychotherapeutic in nature. This assumption has not proved to be the case, and exceptions to the policy have been necessary in the past year.

Given the problems experienced with this policy, it is being rescinded. For dates of service on and after 7/1/87, only services billed under psychotherapy revenue codes by specialty psychiatric hospitals will be counted towards the psychotherapy prior authorization limits. Previously submitted claims which were totally denied may be resubmitted, and those claims which were partially paid may be adjusted.

XV. NEW HEARING AID BATTERY COVERAGE

Effective for dates of service on or after January 1, 1988, the following hearing aid battery will be covered by the WMAP:

HCPCS Procedure Code	Description
W6955	Zinc Air 312

XVI. HMOs PARTICIPATING IN THE HMO PREFERRED ENROLLMENT INITIATIVE - UPDATE

Attachment A of this bulletin includes a listing of HMOs participating in the HMO Preferred Enrollment Initiative (Dane, Milwaukee and Eau Claire Counties), effective January 1, 1988. This attachment updates and replaces information included in the All Provider Bulletin, MAPB-087-036-X, dated October 1, 1987.

Providers must check all MA recipient identification cards carefully to verify eligibility and HMO status each time that services are provided. If no six character HMO code appears on the MA recipient identification card in the column marked "Other Coverage", the recipient may be treated on a fee-for-service basis.

XVII. VOICE RESPONSE SYSTEM (COMPUTERIZED TELEPHONE CORRESPONDENCE)

E.D.S. Federal Corporation (EDS) is implementing a computerized telephone correspondence system effective January 1, 1988. This system, referred to as Voice Response, allows WMAP providers direct access to current, basic MA recipient eligibility information on file at EDS, and the current week's provider checkwrite information. (Reference Section IV.A. of the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987, for additional information on the Voice Response System).

A WMAP Voice Response Manual, with detailed instructions, is included in Attachment B of this bulletin. Please review this manual carefully and retain it for future reference.

XVIII. CORRECTION AND CLARIFICATION OF BILLING INSTRUCTIONS INCLUDED IN PREVIOUS PROVIDER BULLETINS

The following corrects and clarifies information included in previous provider bulletins. Affected providers should read this information carefully and make the noted changes to billing instructions in the referenced provider bulletins.

A. Non-51.42 Board Owned and Operated Day Treatment Providers

Billing instructions included in the Non-51.42 Board Owned and Operated Mental Health, AODA and Day Treatment provider bulletin, MAPB-087-008-E, dated September 1, 1987, instructed Day Treatment providers to enter claim sort indicator "P" in the Program Block/ Claim Sort Indicator element of the HCFA 1500 claim form, effective for all claims received by EDS on and after January 1, 1988. The corrected claim sort indicator for Non-51.42 Board Owned and Operated Day Treatment providers is "M" for all day treatment services. Providers should make this change on the sample claim form and the billing instructions included in MAPB-087-008-E.

Non-51.42 Board Owned and Operated Day Treatment providers should begin using claim sort indicator"M" upon receipt of this bulletin; however, claims will be accepted with claim sort indicator "P" through April 30, 1987. Effective with claims received by EDS on and after May 1, 1988, Non-51.42 Board Owned and Operated Day Treatment providers must enter claim sort indicator "M" on all HCFA 1500 claim forms, or the claims will be denied.

This change applies to Non-51.42 Board Owned and Operated Day Treatment providers only. It does not apply to Mental Health or AODA providers.

B. Rehabilitation Agency Providers

The Rehabilitation Agency Provider Bulletin, MAPB-087-016-D, dated September 1, 1987, instructed Rehabilitation agencies to indicate a performing provider number on all prior authorization (PA) requests and HCFA 1500 claim forms received by EDS on and after January 1, 1988. Rehabilitation providers are exempt from this requirement. Billing instructions included in MAPB-087-016-D should be corrected to delete this requirement. The following are the applicable PA request and claim form elements which should be corrected:

- PA Therapy Attachment, form PA/TA, element #7
- PA Spell of Illness Attachment, form PA/SOIA, element #7
- HCFA 1500 claim form, element #24C

C. Physician Providers

Clarification for Physicians Billing Injectable Drug Services

HCPCS (CPT-4) procedure codes currently billable to the WMAP for injectable drugs, immunizations, and administration of injectable

drugs not supplied by the provider will continue to be billable after the WMAP conversion to HCPCS effective for claims and adjustment requests received by EDS on or after January 1, 1988. In addition to the billable HCPCS (CPT-4) procedure codes included in the Physician Provider Bulletin, MAPB-087-025-A, dated September 1, 1987, the following CPT procedure codes will continue to be billable:

95120 - 95134 Procedure includes the office visit, the allergenic extract and the injection of the allergenic extract.

95135 - 95160 Procedure includes the formulation (preparation) of the antigens for allergen immunotherapy only.

D. Dental Providers

The Dental Provider Bulletin, MAPB-087-008-M, dated November 1, 1987, included in Attachment 3a conversion table of allowable HCPCS Procedure Codes for dental services with an "*" preceding those codes effective January 1, 1988 which require prior authorization.

In addition to those codes annotated with an "*" in MAPB-087-088-M, the following codes will also require prior authorization effective with claims received on or after January 1, 1988:

Code	New Description
* D0270	Bitewing - first film
* D0272	Bitewing - two films
* D0274	Bitewing - four films
* W7833	Stainless steel or crown - first permanent molars
* D3350	Apexification or therapeutic apical closure
* D5216	Upper acrylic partial with two chrome clasps with rest
* D5218	Lower acrylic partial with two chrome clasps with rest
* D5830	Obturator for surgically excised palatal tissue

(* Dental Procedure requires prior authorization)

Dental providers are advised to annotate the HCPCS Procedure Code Conversion Table in MAPB-087-008-M, to include the prior authorization requirements for the above listed procedure codes.

ATTACHMENT A

HMOs PARTICIPATING IN THE HMO PREFERRED ENROLLMENT INITIATIVE

The following table provides the addresses, HMO identification codes and telephone numbers for each MA/HMO contractor. This information reflects contracts effective January 1, 1988 through December 1, 1988, and updates information contained in MAPB-087-036-X, Attachment B, dated October 1, 1987.

Dental services are not always a part of an HMO's services. Recipients enrolled in HMOs which have not contracted for dental services still receive these WMAP-covered services, but they may receive them from any WMAP-certified provider. When an HMO has not contracted to provide dental services, charges for these services should be billed directly to the WMAP on a fee-for-service basis.

NOTE: For an explanation of the information in columns marked 1 through 4 on the following tables, please see the key below.

KEY TO HMO TABLES

(1) a. Enrollment of recipients in WMAP-contracted HMOs is designated on the Medical Assistance Recipient Identification cards in the area under "OTHER COVERAGE" using these six character codes. A three character HMO code on the card indicates private health insurance coverage through an HMO.

b. Enrollment of recipients in WMAP-contracted HMOs is designated on the Voice Response System by a 2 digit HMO code.

(2) Medical Assistance covered services not provided by an HMO may be furnished to enrollees of that HMO by any qualified provider certified to participate in the WMAP and should be billed to E.D.S. Federal Corporation.

(3) Providers may contact an HMO regarding services provided and proper billing procedures by calling the general information telephone number of the HMO on the table.

(4) If a provider is unsure whether a given situation constitutes an emergency, s/he should call the HMO 24-hour emergency telephone number to get the HMO's determination that (a) the situation constitutes an emergency (or in certain instances, a pre-authorized urgent situation) to be treated by the provider, or (b) the situation is such that the patient can be transferred to one of the HMO's providers.

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Date: 12/21/87

MILWAUKEE COUNTY HMOs
January 1, 1988

HMO	Card Designation Voice Response Designation (1)	MA-Covered Not Provided Through the HMO (2)	Information Number (3)	24-Hour Emergency Number (4)
CompCare Health Services 401 W. Michigan St. MILWAUKEE WI 53201	HMOCHS 07		(414)226-6744 or (414)226-5153	(414)289-8661
Family Health Plan Plan 12500 W. Bluemound Ave., P.O. Box 1250 ELM GROVE WI 53122	HMOFAM 08		(414)786-0330	(414)421-8400
Wisconsin Health Organization 2350 W. Villard Ave. MILWAUKEE WI 53209	HMOWHO 09		(414)527-9950	(414)527-9950
MaxiCare/Family Hospital Physicians Associates 1333 N. 12th St. MILWAUKEE WI 53205	HMOMXC 10		(414)933-7661	(414)937-2815 (Emergency Van Hotline)
PrimeCare Health 1233 N. Mayfair Rd. #301 WAUWATOSA WI 53226	HMOPRC 13		(414)453-9070	(414)453-9070
Samaritan Health Plan 1101 N. Market St. #200 MILWAUKEE WI 53202-3114	HMOSAM 14		(414)277-9548	(414)933-7454
Employer's Health Care Plan GREEN BAY WI 54344 (Local) 3237 S. 16th St. MILWAUKEE WI 53215	HMOEHC 12		(414)289-7810	(414)289-7810
MetLife Healthcare Network One Park Plaza Suite 180 MILWAUKEE WI 53224	HMOMET 20		(414)289-7889	(414)289-7889

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DANE COUNTY HMOs
January 1, 1988

HMO	Voice Response Card Designation (1)	Dental Designation	MA-Covered Not Provided Through the HMO Number (2)	Information Number (3)	24-Hour Emergency Number (4)
Group Health Cooperative 1 South Park St. MADISON WI 53715	HMOGHC 02	Dental		(608)251-3356	(608)257-9700 Ext. 444
DeanCare HMO 6515 Grand Teton Plaza MADISON WI 53705-4017	HMODEA 03	Dental		(608)833-7300	(608)833-7300 or 1-800-356-7344
Physicians Plus HMO 345 W. Washington Ave. P.O. Box 14017 MADISON WI 53714-0017	HMOPPP 16	Dental		(608)257-7587	(608)221-5533

EAU CLAIRE COUNTY HMOs
January 1, 1988

HMO	Voice Response Card Designation (1)	Dental Designation	MA-Covered Not Provided Through the HMO (2)	Information Number (3)	24-Hour Emergency Number (4)
Group Health Cooperative of Eau Claire 1030 Regis Court EAU CLAIRE WI 54701	HMOGHE 17	Dental		(715)836-8552	(715)836-8547

(Note: Group Health Cooperative of Eau Claire has a limited panel of chiropractors).

ATTACHMENT B
WMAP VOICE RESPONSE MANUAL

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) Voice Response System is a computerized telephone correspondence system which allows WMAP certified providers direct access to current, basic WMAP recipient eligibility information on file at EDS, and to current week provider checkwrite information.

The provider communicates to the Voice Response System by entering numerically coded data on a telephone pushbutton keyboard. The Voice Response computer responds to the provider using a simulated voice. The Voice Response System is accessed by utilizing the WMAP's revised eight (8) digit provider numbers and ten (10) digit recipient ID numbers.

The Voice Response System is available to certified WMAP providers with touch-tone telephone service by calling 608-221-4247 or 1-800-323-0865, every Monday through Friday from 8:00 a.m. to 5:00 p.m., including holidays.

All providers with touch-tone telephone service are to use the Voice Response System rather than EDS' Telephone Correspondence Unit to obtain eligibility information. This will make the Correspondents more available to providers with policy and billing inquiries. Providers whose local telephone vendors do not provide touch-tone service may continue to contact EDS' Telephone Correspondence Unit.

INFORMATION AVAILABLE FROM THE VOICE RESPONSE SYSTEM

There are two major categories of information available through the Voice Response System: (1) current Medical Assistance Recipient Eligibility and (2) current Provider Checkwrite information.

Medical Assistance Recipient Eligibility -
The Voice Response System is available as a complement to the Medical Assistance recipient identification (ID) card as a source of eligibility information, and can provide the following:

1. Verification of recipient eligibility on a given date, date of birth and medical status.

2. Verification of other coverage, including other insurance, HMO, Medicare Parts A and B, and the recipient's Medicare HIC number.

3. Verification of nursing home level of care authorization and patient liability amount.

EDS' eligibility files are updated by the certifying agencies and the information provided is subject to change without notice. Providers should always review the recipient's current MA card prior to providing services.

Provider Checkwrite Information -
The current week checkwrite amount is available if a check was issued through that week's processing cycle. If no check was issued, the response will so indicate.

ACCESSING THE VOICE RESPONSE SYSTEM

To allow the Voice Response System to be as efficient as possible, certain messages and limitations are designed to assist the system in communicating with the provider.

* The system allows up to 15 seconds for the provider to enter a response when required by the system. If there is no response within 15 seconds, the system disconnects the telephone call.
* Five transactions of any type is the maximum number allowed per telephone call. After the fifth transaction, the system responds with **"TRANSACTION LIMIT HAS BEEN REACHED - THANK YOU FOR CALLING"** and the telephone call is disconnected.
* Following transactions one through four, the system instructs the provider to **"PLEASE ENTER NEXT TRANSACTION"**. This indicates the previous transaction is complete and the system is ready for the next transaction.

INSTRUCTIONS

Dial 608-221-4247 or 1-800-323-0865 between 8:00 a.m. and 5:00 p.m. Monday through Friday, including holidays.

When the system answers your call, you will hear a request to enter your 8 digit provider number and a pound (#) sign. FORMAT: 87654321#

When a valid provider number is keyed, four types of information are accessible by transaction code:

Transaction Code	Description
1	Basic Eligibility Information
2	Patient Liability Information
3	Level of Care Information
4	Provider Checkwrite Information

(1) If RECIPIENT ELIGIBILITY information is desired, please enter the following and then wait for a response.

A. Transaction Code=1
B. Pound Sign #
C. Recipient's 10 Digit MA Number
D. Pound Sign #
E. Date of Service (MMDDYY)
F. Pound Sign #

Format: 1#9876543210#MMDDYY#
(MA No.) (Date of Service)

(2) If PATIENT LIABILITY information is desired, please enter the following and wait for a response.

A. Transaction Code=2
B. Pound Sign #
C. Recipient's 10 Digit MA Number
D. Pound Sign #
E. From Date of Service (MMDDYY)
F. Pound Sign #
G. Through Date of Service (MMDDYY)
H. Pound Sign #

Format: 2#9876543210#MMDDYY#MMDDYY#
(MA No.) (From-Through Dates)

(3) If LEVEL OF CARE information is desired, please enter the following and wait for a response.

A. Transaction Code=3
B. Pound Sign #
C. Recipient's 10 Digit MA Number
D. Pound Sign #
E. From Date of Service (MMDDYY)
F. Pound Sign #
G. Through Date of Service (MMDDYY)
H. Pound Sign #

Format: 3#9876543210#MMDDYY#MMDDYY#
(MA No.) (From-Through Dates)

(4) If current week PROVIDER CHECKWRITE information is desired, please enter the following and wait for a response.

A. Transaction Code=4
B. Pound Sign #
C. Provider Number
D. Pound Sign #

Format: 4#87654321# (Provider No.)

(There is no need to enter a date, as this provides only current date checkwrite information.)

How to Duplicate a Transaction for the Same Recipient

The pound (#) key is an indicator for the end of information. After entering each section of the transaction, a # key must be entered. It can also be used for duplicate transactions for the same recipient.

Example: You have already completed your first Transaction 1, request for eligibility information (1#9876543210# MMDDYY#). To obtain eligibility information for an additional Date of Service for the same recipient, enter (1##MMDDYY#). This indicates duplicate information for the same transaction and the same recipient number is requested.

How to Intercept an Erroneous Transaction

If, while entering the transaction, you realize an error has been made, it is not necessary to enter all the information.

Example: You realize you entered the MA number incorrectly. To interrupt the transaction, enter invalid characters, e.g., do not enter the full Date of Service (#1#98765433210#0#). By entering a 0 rather than the actual Date of Service, you will receive a message saying "**INVALID TRANSACTION, PLEASE READ INSTRUCTIONS AND RE-ENTER**". If you make an error while entering the MA number, again enter invalid information, e.g., (1#9877#0#) to intercept the transaction. This will generate the same message.

VOICE RESPONSE VOCABULARY

A. **Hello, please enter your Wisconsin Medical Assistance provider number. (REMINDER: You must enter a pound (#) sign immediately following your provider number.)**

Example: 87654321#

* Response if Error Detected: Unauthorized number, please re-enter.

* When initially signing on to the Voice Response System, if three invalid provider numbers are entered consecutively, the telephone call is ended along with a message saying, **"SORRY, THE PROVIDER NUMBERS YOU HAVE ENTERED ARE INVALID"**.

* Response if Valid: Always review recipient's current medical assistance card for eligibility before providing service. Please begin transaction.

B. **BASIC ELIGIBILITY INFORMATION:**

Transaction Code 1#9876543210#MMDDYY#
(MA No.) (Date of Service)

* Response if Ineligible: MA #9876543210 for date of service MMDDYY is not eligible for medical assistance services.

* Response if Eligible: MA #9876543210, date of birth MMDDYY is eligible for MMDDYY for (No) other insurance and (No) Medicare (A), (B), (A and B) (HIC #333333333333). This recipient is (medically) or (categorically) needy.

* If Restrictions Apply: Recipient is enrolled in HMO __ [code].

* Response if Dates Not Carried on System: Information for MA #9876543210 for date of service MMDDYY is not available on Voice Response. Please check MA card and call Correspondence for additional information.

* The amount of eligibility information available is limited, and varies for each recipient. Therefore, do not assume that dates unavailable for one recipient will be unavailable for another recipient.

Example: For recipient 0123456789, you enter the date 10/1/87, which is beyond this recipient's available information, the system responds with **"INFORMATION FOR DATES ENTERED IS NOT AVAILABLE ON VOICE RESPONSE - PLEASE CHECK MA ID CARD AND CALL CORRESPONDENCE FOR ADDITIONAL INFORMATION."**

For recipient 9876543210, you enter the same date (10/1/87), and the date is available for this recipient, the system responds **"MA#9876543210, date of birth MMDDYY is or is not eligible"**.

C. **PATIENT LIABILITY INFORMATION:**

Transaction Code 2#9876543210#MMDDYY#MMDDYY#
(MA No.) (From-Through Dates)

*Response:

1. For MA #9876543210, dates MMDDYY through MMDDYY, liability on file is $XXX.XX.

2. For MA #9876543210, dates MMDDYY through MMDDYY, no liability is on file.

NOTE: For both responses there is a final statement saying: "For correction of file information, please contact the certifying agency."

If there is more than one liability amount on file for the dates entered, both amounts and the from-through dates for each are stated.

D. **LEVEL OF CARE INFORMATION:**

Transaction Code 3#9876543210#MMDDYY#MMDDYY#
(MA No:) (From-Through Dates)

* Response:

1. No level of care on file for MA#9876543210, dates MMDDYY through MMDDYY.

2. Level of care on file is ___ for MA#9876543210 for MMDDYY through MMDDYY for another facility.

3. Level of care on file is __ for MA#9876543210 for dates MMDDYY through MMDDYY.

NOTE: For all responses, there is a final statement saying: "For correction of file information, please contact the Division of Health".

If either the provider number, or dates entered do not match our files exactly, or if multiple levels of care correspond to the dates or provider number entered, more than one response is stated.

E. **CHECKWRITE INFORMATION:**

Transaction Code 4#87654321# (Current Date Checkwrite Information)

* If check: For payment cycle MMDDYY, your payment is $XXX.XX.

* If no check: There was no check issued MMDDYY.

ATTACHMENT C
APPROVED ORGAN TRANSPLANT INSTITUTIONS

* *

Heart Transplants:	University of Wisconsin Hospital and Clinics, Madison, WI *Presbyterian-University Hospital Pittsburgh, PA *Stanford University Hospital, Stanford and Palo Alto, CA St. Luke's Hospital, Milwaukee, WI
Pancreatic Transplants	University of Wisconsin Hospital and Clinics, Madison, WI
Liver Transplants	University of Wisconsin Hospital and Clinics, Madison, WI *Presbyterian-University Hospital, Pittsburgh, PA *University of Minnesota Hospital and Clinics, Minneapolis, MN *Methodist Hospital (affiliated with Mayo Clinic), Rochester, MN Froedtert Hospital, Milwaukee, WI
Heart-Lung Transplants	University of Wisconsin Hospital and Clinics, Madison, WI

* These hospitals currently may not accept the Wisconsin State Medical Assistance rate established for transplantations.

Physicians and hospital discharge planners should refer transplant patients to only those hospitals that will accept the rate. If a facility will not accept a WMAP recipient, contact the State Medical Consultant at (608) 266-2421.