

Medical Assistance Provider Bulletin

Attention: All Title XIX
Certified Hearing Aid Dealers,
Audiologists, and Speech and
Hearing Clinics

Subject: Certification
Policy and Billing
Clarification

Date: February 15, 1989

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This bulletin contains important information on certification policy and billing procedures under the Wisconsin Medical Assistance Program (WMAP). These include the following:

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I. CERTIFICATION REQUIREMENTS

All hearing aid dealers receiving reimbursement for services provided to Medical Assistance recipients are, under sec. HSS 105.01(4), Wis. Adm. Code, required to be individually certified with the Wisconsin Medical Assistance Program (WMAP). For certification as a Wisconsin Medical Assistance Provider, sec. HSS 105.41, Wis. Adm. Code requires that hearing aid dealers be licensed pursuant to sec. 459.05, Stats.

Hearing aid dealers in group practice may obtain a group billing number which can be used for submitting claims for certified members of the group. Each individual hearing aid dealer must, however, be individually certified with the WMAP. This is a long-standing requirement of the WMAP. However, recent audits conducted by the Bureau of Health Care Financing (BHCf) have revealed that there is general non-compliance with this requirement. Rather than selectively penalizing certain providers for what appears to be a general misunderstanding of this requirement, the WMAP is taking this opportunity to clarify this requirement and afford providers the opportunity to come into compliance by obtaining the required provider certifications.

To obtain an application for certification, call the EDS Correspondence Unit or write to the following address:

EDS Federal Corporation
ATTN: Provider Maintenance
6406 Bridge Road
MADISON WI 53784-0006

Effective for dates of service on and after June 1, 1989, any claims submitted for services provided by hearing aid dealers who are not individually certified will be subject to denial or recoupment. Providers who become newly certified may not submit claims under the new individual or billing provider name and number for any dates of service prior to the effective date of certification, or the claims will be denied. Instructions on proper completion of the HCFA 1500 claim form, using individual performing provider numbers and group billing provider numbers, are given in Section II.A. of this bulletin.

Claims which indicate an individual performing provider number and a group billing number must be for dates of service on or after the effective dates of both provider numbers, or the claims will be denied.

II. CLARIFICATION OF BILLING INSTRUCTIONS

A. Provider Name and Number

Hearing aid providers are experiencing a large number of claims denials due to incorrect placement of the provider name(s) and number(s) on the claim form. This is particularly true of clinics using a clinic name and clinic billing provider number. Please review the Billing Instructions contained in the Hearing Aid and Audiology Medical Assistance Provider Bulletin MAPB-087-015-D/002-HA dated September 1, 1987.

Clinics which use a clinic billing provider number must indicate the clinic name and billing number in Element 31 of the HCFA 1500 claim form and the individual performing provider name and individual number in Element 24C of the claim form. If different performing providers within the group supply different services to an individual recipient, indicate each performing provider name and number under each service detail in Element 24C. The first line in Element 31 of the claim form must be the clinic name and the last line must be the clinic billing number, and both must match exactly the name and numbers on the WMAP's certification file. Refer to Attachment 2 for a claim form example.

Providers may bill under their individual performing provider number, whether they practice individually or in a group. In this situation, the individual name must be the first line in Element 31 of the claim form and the performing provider number is on the last line. The performing provider does not need to be indicated in Element 24C.

B. Claim Sort Indicators

The Wisconsin Medical Assistance Provider Bulletin MAPB-087-015-D/002-HA dated September 1, 1987, did not clearly explain the claim sort indicator. The claim sort indicator must be indicated in the "Medicaid" check box in the upper left-hand corner of the HCFA 1500 claim form. The appropriate claim sort indicator for services billed by audiologists and hearing aid dealers are as follows:

<u>Provider Type</u>	<u>Type of Service</u>	<u>Claim Sort Indicator</u>
Audiologist	Audiological Services (i.e., therapies)	T
Audiologist	Servicing and supplying of hearing aids	D
Hearing Aid Dealer	Servicing and supplying of hearing aids	D

Claims submitted without the claim sort indicator or with an improper indicator will be denied.

Audiologists are reminded that audiological services (i.e., therapies) and hearing aids/supplies may not be billed on the same claim form, due to different claim sort indicators.

C. Battery Procedure Codes

Hearing aid providers are reminded that a large number of hearing aid battery procedure codes were consolidated or deleted effective for dates of service on and after January 1, 1988. The updated procedure codes for batteries are listed in Medical Assistance Provider Bulletin MAPB-087-015-D/002-HA, dated September 1, 1987. Hearing aid providers are experiencing a large number of denials because old battery procedure codes are being used when submitting claims.

Requests for additions to the battery listing may be submitted to:

Bureau of Health Care Financing
Attn: Hearing Analyst
P.O. Box 309
MADISON WI 53701

D. Incorrect Denials

Referring/Attending Provider

Some hearing aid providers have received a 91 Explanation of Benefit (EOB) code ("Referring/Attending provider required") on claims submitted for hearing aid batteries, repairs and accessories which were not part of the initial service. This is an incorrect denial for these services and providers are asked to resubmit the denied claims to EDS.

Performing Provider/Prior Authorization

Some hearing aid providers have received a 400 EOB code ("Performing provider on the claim must be the same as the performing provider who received prior authorization for this service") on claims submitted for hearing aid services. These claims were incorrectly denied and providers may resubmit the denied claims to EDS.

E. Procedure Code 92599 - Other Audiological Procedures

Procedure Code 92599 is listed in MAPB-087-015-D/002-HA as billable, however, the State Consultant has determined that use of this code is inappropriate. There is a specific procedure code available to cover each audiological service. Claims submitted with procedure code 92599 will be denied.

III. COMMON EXPLANATION OF BENEFIT (EOB) CODES

In an effort to help providers avoid unnecessary denials, a list of the most common hearing aid and audiological Explanation of Benefit (EOB) codes and suggestions for resolving them is presented below. As a reminder, providers may resubmit legible copies of denied paper claims, with appropriate corrections, to EDS for processing (photocopies are acceptable) through normal processing channels.

For providers who submit claims through telephone transmission or tape billing, the resolutions listed below may not be applicable. Providers who submit claims through telephone transmission or tape billing, and have questions regarding the following common rejections, should contact the EMC Unit at EDS for assistance at (608) 221-4746. All other providers should contact the EDS Correspondence Unit for assistance. Please refer to Wisconsin Medical Assistance Provider Bulletin MAPB-087-037-X dated September 1, 1987 for the correct telephone numbers.

- A. EOB CODE 229: "The claim sort indicator is missing or incorrect."

RESOLUTION: A valid claim sort indicator must be indicated in the "Medicaid" box in the upper left-hand corner of the HCFA 1500 claim form. The valid claim sort indicators are listed in section II.B of this bulletin.

- B. EOB Code 278: "Denied, Recipient eligibility file indicates other insurance - Submit claim to other insurance carrier."

The 278 EOB may occur in the following situations:

1. The recipient has private insurance which covers the service, but the provider did not bill the third party insurer.

RESOLUTION: Medical Assistance is the payer of last resort and therefore all private insurance must be billed prior to billing Medical Assistance.

2. The provider may have billed the third party insurer, but did not indicate an "other insurance disclaimer code" in Element 9 ("other health insurance coverage") of the HCFA 1500 claim form.

RESOLUTION: After receiving a response from the private insurance, please indicate the appropriate "other insurance disclaimer code" in Element 9 of the HCFA 1500 claim form. Other insurance disclaimer codes may be found in Medical Assistance Provider Bulletin MAPB-087-015-D/002-HA, dated September 1, 1987.

Please note: If the private insurance makes payment on the charges, disclaimer code "01-P" must be indicated in Element 9 and the amount paid must be indicated in Element 28 ("amount paid") of the HCFA 1500 claim form. Do not attach the private insurance EOB report.

3. The recipient insists he/she does not have private insurance. However, the Medical Assistance ID card and EDS file indicate private insurance.

RESOLUTION: The provider may indicate "Other insurance disclaimer code", OI-R ("recipient denies coverage") in Element 9 of the HCFA 1500 claim form and submit the claim for processing. The provider should also have the recipient contact the local certifying agency to correct any insurance discrepancies.

- C. EOB CODE 281: "Recipient number is not listed on our current eligibility file. Consult with local social service agency."

Providers often assume the 281 EOB means that the recipient is not eligible. However, a 281 EOB may mean that one of the following problems are occurring:

1. The provider is not indicating the correct 10 digit Medical Assistance (MA) Recipient Identification (ID) number in Element 6 ("insured's ID number") of the HCFA 1500 claim form.

RESOLUTION: Providers are reminded to always use the MA ID number which appears on the valid MA card when submitting their claims. Effective January 1, 1988, all recipient ID numbers are 10 numeric digits (numbers) long.

2. The provider is not indicating the correct number of digits for the recipient's ID number.

RESOLUTION: Effective with all claims and adjustments received on and after May 1, 1988, the new 10 digit MA number must be used. The 10-digit MA number may be obtained from the recipient's current MA ID card.

3. The provider is indicating the Medical Status information code on the claim form as part of the MA ID number.

RESOLUTION: The Medical Status information codes appear just before the 10-digit number on the MA ID card (i.e., "*" for Medically Needy or "N*" or "N" for Nursing Home Recipients). These informational codes must not be indicated on the claim form.

- D. EOB CODE 388: "Incorrect or invalid type of service/NDC/Procedure Code/Accommodation Code or Ancillary Code Billed."

The 388 EOB usually occurs when the provider has missing and/or incorrect information in Elements 24C ("Procedure") and/or 24G ("TOS") of the HCFA 1500 claim form. This EOB most often occurs when:

1. The provider is not indicating a correct procedure code in Element 24C of the HCFA 1500 claim form.

RESOLUTION: Indicate a valid procedure code in Element 24C, "Procedure Code (identify)," and a matching description for each service performed. Valid procedure codes may be found in Medical Assistance Provider Bulletin MAPB-087-015-D/002-HA dated September 1, 1987. The EDS Correspondence Unit can verify if a procedure code is a valid WMAP procedure code. However, the Correspondence Unit cannot suggest valid codes to use in submitting claims.

2. The provider is not indicating a correct type of service (TOS) code in Element 24G for the procedure indicated on the claim form.

RESOLUTION: A valid type of service code for each procedure must be indicated in Element 24G. Valid type of service codes may be found in Medical Assistance Provider Bulletin MAPB-087-015-D/002-HA, dated September 1, 1987.

- E. EOB CODE 424: "Billing Provider name/number is missing, mismatched or unidentifiable. Indicate 1 billing provider name/number in the appropriate element. Performing provider must be indicated on each detail."

The billing provider name and number must be indicated in Element 31 of the HCFA 1500 claim form. A 424 EOB code occurs when:

1. The billing name and billing provider number do not correspond with the billing provider's name and number as it appears on EDS' files.

RESOLUTION: The provider name indicated in Element 31 must be identical to the provider name filed with EDS when the provider became certified or recertified. The billing number the provider uses must be the billing number assigned by EDS.

2. The provider's billing number is not the correct eight digit number.

RESOLUTION: Effective for claims submitted on or after January 1, 1988, providers must use the eight digit provider number.

3. The provider's billing name and/or billing provider number is not clearly legible, or is not indicated in Element 31 of the claim form.

RESOLUTION: Indicate a provider billing name and corresponding billing number in Element 31 of the claim form. Providers are reminded to only indicate one WMAP provider number in Element 31.

- F. EOB CODE 425: "Performing Provider name/number is missing, mismatched, or unidentifiable. Indicate Performing Provider name/number separately on each detail." This occurs when:

1. The only provider number indicated on the claim form is in Element 31 and is a clinic provider number.

RESOLUTION: Beneath the description of service in Element 24C, enter the name and eight digit provider number of the performing provider if different than the billing provider number indicated in Element 31. All hearing aid and audiology claims must indicate the name and number of the individual performing the service.

2. The provider name and number indicated in Element 24C do not correspond with the provider name and number on file.

RESOLUTION: The provider's name and number indicated in Element 24C must be identical to the provider's name and number on file at EDS. Correct the claim or contact EDS to change the provider file.

3. The provider name and number in Element 31 is a billing number and the performing provider's name or number is not indicated in Element 24C of the claim form.

RESOLUTION: The performing provider's name and number must both be indicated in Element 24C if different than the billing provider's name and number indicated in Element 31.

- G. EOB CODE 100: "Claim previously/partially paid on XXXXXXXXXXXXXXXX on RA date XXXXXX. Adjust paid claim."

In this instance the provider has submitted a claim that is a duplicate of one previously submitted. The claim is a duplicate of a claim already paid.

RESOLUTION: The claim number and date the claim paid will be indicated in the EOB 100 message. The provider should then check that Remittance and Status Report for the paid claim. If the provider feels this payment was inappropriate, an adjustment must be submitted.

- H. EOB 102: "Duplicate item of a claim being processed. Please do not file a duplicate claim."

This EOB is similar to EOB 100 and occurs when the claim is a duplicate of a claim currently in some processing stage at EDS.

RESOLUTION: The claim is being denied for being a duplicate while the processing of a duplicate claim continues. The provider should check subsequent Remittance and Status Reports, including the "pending claims" listing from the next end-of-month Remittance and Status Report. If the claim does not process nor appear as pending on the end-of-month listing, the provider may contact the EDS correspondence unit to verify the claims' status. Do not submit another claim for these services until all claims for that date of service have been processed.

Filing duplicate claims delays processing and increases the provider's administrative costs. Review all Remittance and Status Reports carefully to avoid filing duplicates.

IV. SUGGESTIONS FOR ELECTRONIC BILLING AND PROVIDER COMMUNICATIONS

- A. Please Stop the Paperwork!

Did you know that the average electronic claim processes in about half the time of the average paper claim? Did you know "paperless providers" have about one-third fewer billing errors than paper billers? EDS has free software and consultation services to help providers move into the world of paperless claims. Just fill out the attached questionnaire (Attachment 1) and send it in, or call (608) 221-4746 and ask for more information from the EMC Unit.

- B. Tired of Listening to Busy Signals?

EDS has more than doubled its phone capacity in 1988. EDS' Provider Services staff answers the equivalent of one call from every provider every month and has answered in 1988 three times the number of calls answered in 1987. The WMAP is aware that many providers are having trouble contacting EDS correspondents. Here are some suggestions to avoid problems:

- Use the recipient MA ID card each time services are provided. More than forty percent of all calls to the EDS correspondents are for eligibility information contained on the cards. Without these calls EDS would be able to answer nearly twice as many policy calls.
- Use Voice Response for current eligibility information when the MA ID card is not available. The (608) 221-4247 number for Voice Response is available nearly 24 hours a day, seven days a week to accommodate emergency and weekend service. For more information on Voice Response, please see Attachment B from the Wisconsin Medical Assistance Provider Bulletin MAPB-087-038-X, dated December 21, 1987.
- Use the (608) 221-9773 (Southeastern counties) and (608) 221-9236 (balance of state) numbers. These numbers are not nearly as busy as the toll-free numbers.
- Call early in the morning (lines open at 8:00 AM), at lunch time, or in late afternoon (lines close at 5:00 p.m.) to avoid the 10-12 and 1-3 peak periods of demand. Please note: correspondence lines, other than Voice Response, will not be staffed from 8:30 - 9:30 a.m., the first and third Tuesday of each month, to accommodate correspondent training.

SECTION V
ATTACHMENTS

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DATE: 2/15/89

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ATTACHMENT 1
ELECTRONIC MEDIA SURVEY
PROVIDER QUESTIONNAIRE

Name: _____

Address: _____

Medicaid Number: _____ Phone #: _____

Contact Person: _____

Type of Service(s) Provided: _____

-
1. Do you currently submit your Medicaid claims on paper? YES NO
 2. Are your Medicaid claims computer generated on paper? YES NO
 3. Do you use a billing service? YES NO
If the answer is YES to #2 or #3, please complete the following:

Name: _____ Contact: _____

Address: _____ Phone #: _____

4. Do you have an in-house computer system? YES NO
If YES, type of computer system:

a. Large main frame Manufacturer: _____
(i.e., IBM 360, Burroughs 3800) Model #: _____

b. Mini-Computer Manufacturer: _____
(i.e., IBM System 34, or 36 TI 990) Model #: _____

c. Micro-Computer Manufacturer: _____
(i.e., IBM PC, COMPAQ, TRS 1000) Model #: _____

5. Would you be interested in simplifying your claims submission?

a. YES, via magnetic tape submission

b. YES, via telephone transmission

c. YES, via 3780 transmission

RETURN TO: E.D.S. Federal Corporation
 ATTN: EMC Department
 6406 Bridge Road
 MADISON WI 53784-0009

