

# Medical Assistance Provider Bulletin

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

**Subject:** New HCFA 1500 Claim Form; 1992 CPT  
Procedure Codes

**Date:** March 15, 1992

**Code:** MAPB-092-009-K

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

## TABLE OF CONTENTS

- I. INTRODUCTION
- II. NEW NATIONAL HCFA 1500 CLAIM FORM
- III. 1992 CURRENT PROCEDURAL TERMINOLOGY (CPT)
- IV. PLACE OF SERVICE CODES
- V. ATTACHMENTS

## I. INTRODUCTION

This Medical Assistance Provider Bulletin (WMA) provides important information on the Wisconsin Medical Assistance Program's (WMA) implementation of a new HCFA 1500 claim form and 1992 Current Procedural Terminology (CPT) procedure codes. It is important that providers review this information carefully and share it with billing staff.

Providers should pay particular attention to the text and Attachments 1 and 2 of this MAPB for information on new billing procedures and policies.

## II. NEW NATIONAL HCFA 1500 CLAIM FORM

The Health Care Financing Administration (HCFA) has mandated that all state Medicaid programs use the revised National HCFA 1500 claim form (dated 12/90). All paper claims received by EDS from March 15, 1992, through May 1, 1992, may be submitted on either the current HCFA 1500 claim form (dated 1/84) or the new claim form.

All claims, including the resubmission of any previously denied claims, received by EDS after May 1, 1992, must be submitted on the HCFA 1500 claim form dated 12/90. Claims received by EDS after May 1, 1992, on claim forms other than the HCFA 1500 (12/90) claim form, will be denied. Modified versions of the National HCFA 1500 claim form may also be denied.

**Please allow ample mailing time to ensure that claims submitted on the current HCFA 1500 claim form are received at EDS by May 1, 1992.**

Crossover claims for Medicare Part B coinsurance and deductible allowed charges may be submitted on either the new or old HCFA 1500 claim form.

There are no changes to the submission of electronic claims.

A sample claim form and detailed claim form completion instructions are included in Attachments 1 and 2 of this MAPB. All claims received by EDS on the new HCFA 1500 claim form must be completed according to these instructions. The instructions in this MAPB completely replace the instructions you received in MAPB-087-008-K dated September 1, 1987.

As you read the completion instructions in Attachment 2, please watch for the following changes:

- The procedure code is now indicated in Element 24D of the claim form, but the procedure code description is no longer required.
- An emergency condition must be indicated for each applicable line item on the claim form by entering an "E" in Element 24I.
- Family planning services and services resulting from HealthCheck (EPSDT) referrals must be indicated for each applicable line item on the claim form by entering "F" for family planning services, "H" for HealthCheck services, or "B" for both in Element 24H.

- Providers billing lab handling fees are no longer required to indicate the name of the independent lab where specimens are sent. However, the "Yes" box in Element 20 must be checked when a lab handling fee is billed.

The National HCFA 1500 claim form is not provided by either the WMAP or EDS, but may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.  
P.O. Box 1109  
Madison, WI 53701  
(608) 257-6781  
1-800-362-9080

### III. 1992 CURRENT PROCEDURAL TERMINOLOGY (CPT)

Effective with dates of service on or after January 1, 1992, the WMAP began accepting the allowable procedure codes from the 1992 edition of the Current Procedural Terminology (CPT) published by the American Medical Association, subject to the following conditions:

- For dates of service prior to January 1, 1992, the WMAP is accepting only 1991 CPT codes. Claims submitted with inappropriate procedure codes for the date of service being billed are denied.
- For claims received by EDS prior to April 1, 1992, for dates of service January 1, 1992, through March 31, 1992, the WMAP is accepting either the 1991 or 1992 CPT procedure codes.
- Claims received by EDS on or after April 1, 1992, for dates of service on or after January 1, 1992, must indicate 1992 CPT procedure codes.

Copies of the 1992 CPT may be purchased by writing to the American Medical Association at the address listed in Appendix 3 of Part A of the WMAP Provider Handbook. Providers are referred to the 1991 and 1992 CPT for the appropriate procedure codes for the date of service being billed.

### IV. PLACE OF SERVICE CODES

Until further notice, the WMAP will continue to require the single-digit place of service codes on the HCFA 1500 claim, not the two-digit place of service codes required by Medicare. Claims with Medicare Part B allowed charges that cross over to the WMAP from WPS will have the place of service codes automatically converted to single-digit codes for claims processing. However, paper crossover claims, as well as all paper and electronic claims submitted directly to the WMAP, must indicate the appropriate single-digit place of service code.

## **ATTACHMENTS**

1. **National HCFA 1500 Claim Form Sample**
2. **National HCFA 1500 Claim Form Completion Instruction**
3. **WMAP Allowable Place of Service (POS) and Type of Service (TOS) Codes**

ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM SAMPLE  
FOR LABORATORY AND  
PORTABLE X-RAY SERVICES

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A				3 PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4 INSURED'S NAME (Last Name, First Name, Middle Initial)					
5 PATIENT'S ADDRESS (No., Street) 609 Willow St.				6 PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No., Street)					
CITY Anytown		STATE WI		8 PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ( )			
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-D				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX				12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					
c. EMPLOYER'S NAME OR SCHOOL NAME				14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
d. INSURANCE PLAN NAME OR PROGRAM NAME				17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring		17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.				19 RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 V725 3 _____ 2 _____ 4 _____				23 PRIOR AUTHORIZATION NUMBER		24 A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSTD Family Plan I EMG J COB K RESERVED FOR LOCAL USE		25 FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>			
25 FEDERAL TAX I.D. NUMBER		SSN EIN		26 PATIENT'S ACCOUNT NO 1234JED		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28 TOTAL CHARGE \$ XX XX			
29 AMOUNT PAID \$		30 BALANCE DUE \$ XX XX		31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) I.M. Authorized MM/DD/YY SIGNED _____ DATE _____		33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321					

ATTACHMENT 2

**NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS  
FOR LABORATORY AND PORTABLE X-RAY SERVICES**

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

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

**ELEMENT 1 - Program Block/Claim Sort Indicator**

Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

**ELEMENT 1a - INSURED'S LD. NUMBER**

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

**ELEMENT 2 - PATIENT'S NAME**

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

**NOTE:**

A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

**ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX**

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

**ELEMENT 4 - INSURED'S NAME (not required)**

**ELEMENT 5 - PATIENT'S ADDRESS**

Enter the complete address of the recipient's place of residence.

**ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)**

**ELEMENT 7 - INSURED'S ADDRESS (not required)**

**ELEMENT 8 - PATIENT STATUS (not required)**

**ELEMENT 9 - OTHER INSURED'S NAME**

Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes **MUST** be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

<b>Code</b>	<b>Description</b>
OI-P	PAID by other insurance, in whole or in part
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

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

<b>Code</b>	<b>Description</b>
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: <ul style="list-style-type: none"><li>- noncovered service</li><li>- applied to deductible or copayment</li><li>- family planning services (if WPS-HMP only)</li></ul>

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

**ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)**

**ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER**

The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes **MUST** be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, this element may be left blank. If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

**ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE**

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

**ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY** (not required)

**ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS** (not required)

**ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** (not required)

**ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

When required, enter the referring or prescribing physician's name.

**ELEMENT 17a - LD. NUMBER OF REFERRING PHYSICIAN**

Enter the referring provider's eight-digit Medical Assistance provider number if certified by the WMAP. If the referring provider is not WMAP-certified, enter the provider's license number.

**ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** (not required)

**ELEMENT 19 - RESERVED FOR LOCAL USE**

If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

**ELEMENT 20 - OUTSIDE LAB**

If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

**ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

**ELEMENT 22 - MEDICAID RESUBMISSION (not required)**

**ELEMENT 23 - PRIOR AUTHORIZATION**

Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

**ELEMENT 24A - DATE(S) OF SERVICE**

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

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

**ELEMENT 24B - PLACE OF SERVICE**

Enter the appropriate WMAP single-digit place of service code for each service. Refer to Attachment 3 of this MAPB for a list of allowable place of service codes.

**ELEMENT 24C - TYPE OF SERVICE CODE**

Enter the appropriate single-digit type of service code. Refer to Attachment 3 of this MAPB for a list of allowable type of service codes.

**ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES**

Enter the appropriate five-character procedure code and, if applicable, a two-character modifier.

**ELEMENT 24E - DIAGNOSIS CODE**

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

**ELEMENT 24F - CHARGES**

Enter the total charge for each line.

**ELEMENT 24G - DAYS OR UNITS**

Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

**ELEMENT 24H - EPSDT/FAMILY PLANNING**

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

**ELEMENT 24I - EMG**

Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

**ELEMENT 24J - COB (not required)**

**ELEMENT 24K - RESERVED FOR LOCAL USE**

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

**ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)**

**ELEMENT 26 - PATIENT'S ACCOUNT NO.**

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

**ELEMENT 27 - ACCEPT ASSIGNMENT**

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

**ELEMENT 28 - TOTAL CHARGE**

Enter the total charges for this claim.

**ELEMENT 29 - AMOUNT PAID**

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

**ELEMENT 30 - BALANCE DUE**

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

**ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER**

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

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

**ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED**

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

**ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #**

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

ATTACHMENT 3

WMAP ALLOWABLE PLACEMENT OF SERVICE (POS)  
AND TYPE OF SERVICE (TOS) CODES

\*\*\*\*\*

PLACE OF SERVICE (POS) TABLE

<u>Code</u>	<u>Description</u>
4	Home
7	Nursing Home
8	Skilled Nursing Facility
A	Independent Lab

TYPE OF SERVICE (TOS) TABLE

<u>Code</u>	<u>Description</u>
5	Diagnostic Lab (total) (includes EKG)
4	Diagnostic X-ray (total)
U	Diagnostic X-ray (technical component)
B	Diagnostic Medical (total) (includes EKG)