# Medical Assistance Provider Bulletin

**Attention:** All Title Certified Free Standing Ambulatory Surgery Centers

**Subject:** CLIA; New "OI" Codes and Claim Form Instructions

**Date:** September 14, 1992

**Code:** MAPB-092-009-O

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

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## I. *INTRODUCTION*

This Medical Assistance Provider Bulletin (MAPB) provides important information on changes in the Wisconsin Medical Assistance Program's (WMAP) reimbursement for laboratory services and billing requirements on the HCFA 1500 claim form. ***It is imperative that providers review this information carefully and share it with billing staff.***

## II. *NEW CERTIFICATION REQUIREMENT AND POLICY FOR REIMBURSEMENT OF LABORATORY SERVICES*

All laboratories which test human specimens to determine health status are covered by the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988. This includes independent laboratories, clinics, and individual physician offices which perform lab tests. CLIA governs every aspect of laboratory operation, including tests performed, personnel qualifications, quality control, quality assurance, proficiency testing, patient test management, and records and information systems.

Every provider that performs laboratory tests must obtain a CLIA identification number **and** a certificate of waiver or a certificate of registration from the Health Care Financing Administration (HCFA). A laboratory may qualify for a certificate of waiver if it restricts its testing to the eight specific tests identified by HCFA as waived tests. A laboratory performing other than waived tests is issued a certificate of registration.

**Effective with dates of service on or after September 1, 1992, reimbursement for laboratory services is limited to procedures for which the provider has a valid CLIA identification number.** Claims for lab tests performed by providers that do not have a valid CLIA identification number are subject to denial or recoupment.

Providers are not required to indicate a CLIA number on claims for laboratory services. The WMAP will obtain CLIA numbers from HCFA, and will cross-reference your CLIA number to your Medical Assistance provider number.

To assist EDS in updating your provider file and assure continued payment of claims for laboratory services, please send a copy of your CLIA approval letter from HCFA indicating your CLIA number. Please write your Medical Assistance provider number at the top of the letter and submit it to the following address:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

If your laboratory does not have a CLIA identification number, write to the following address:

Bureau of Quality Compliance
Attn: Sandy Frank
P.O. Box 309
MADISON WI 53701

(608) 266-2966

Questions concerning the status of a CLIA application should be directed to the federal CLIA Hotline at (410) 290-5850.

## III. *REVISED HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS*

***Revised HCFA 1500 claim form instructions are included as Attachment 1 of this MAPB. These instructions are effective with claims received by EDS on or after January 4, 1993. All claims, including resubmission of any previously denied claims, received by EDS on or after January 4, 1993, must be submitted according to the instructions included with this MAPB. This applies to all paper claims, electronic claims, and crossover claims for coinsurance and deductible for Medicare Part B allowed charges.***

***All claims received by EDS prior to January 4, 1993, must be submitted according to the claim form completion instructions in MAPB-092-007-O dated February 28, 1992. Please retain these instructions to ensure the accurate submission of claims.***

**Important Note:** Please allow ample mailing time to ensure that claims submitted according to the instructions in MAPB-092-007-O dated February 28, 1992, are received by EDS prior to January 4, 1993. If there is a likely possibility that claims prepared and mailed in late December 1992 will not be received by EDS prior to January 4, 1993, it is to the provider's advantage to submit claims according to the instructions included with this MAPB after January 4, 1993.

Please pay particular attention to the following changes. You are encouraged to review the claim form completion instructions in their entirety, as some additional areas have been reworded to clarify WMAP billing requirements.

### A. *"Other Insurance" Indicators*

The WMAP has reduced the number of allowable "Other Insurance" (OI) codes to simplify billing for providers and increase the accuracy of information received on claims. Claims received on or after January 4, 1993, which do not indicate allowable "OI" codes will be denied. Refer to the HCFA 1500 claim form completion instructions in Attachment 1 of this MAPB for allowable "OI" codes for claims received on or after January 4, 1993.

### B. *Medicare Disclaimer Codes*

The WMAP has changed the descriptions of the Medicare disclaimer codes, required in element 11 of the HCFA 1500 claim form, to clarify the correct use of the codes. Refer to the HCFA 1500 claim form completion instructors in Attachment 1 of this MAPB for the new descriptions.

C. ***Referring Provider***

The WMAP requests that a referring provider's Unique Physician Identification Number (UPIN) be indicated in element 17A of the HCFA 1500 claim form. If a UPIN number is not available, the referring provider's individual WMAP provider number or license number may be used. Providers may obtain a UPIN directory from the following address:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
(202) 783-3238

D. ***Modifiers***

EDS will be able to process claims which indicate two valid modifiers for each procedure code in the "Modifier" column in element 24D of the HCFA 1500 claim form. Only specific modifiers which are appropriate to the procedure billed are accepted by the WMAP. Allowable WMAP modifiers vary in some cases from those used in the CPT coding structure and by Medicare. Providers should carefully review their MAPBs to make sure they are using only the valid WMAP modifiers for their provider area.

## IV. *REIMBURSEMENT*

Effective with dates of service on or after October 1, 1992, the WMAP will reimburse ambulatory surgery centers only one maximum fee per date of service. If more than one procedure is billed per date of service, reimbursement will be based on the procedure with the highest allowed amount.

## ATTACHMENTS

1. HCFA 1500 Claim Form Completion Instructions

## ATTACHMENT 1

## NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR FREE STANDING AMBULATORY SURGERY CENTER SERVICES

(for Claims Received On or After January 4, 1993)

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 I.D. 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 Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, 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.)

| Code | Description |
|---|---|
| OI-P | PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim. |
| OI-D | DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer. |
| OI-Y | YES, card indicates other coverage but it was not billed **for reasons including,** but not limited to:<br>• Recipient denies coverage or will not cooperate;<br>• The provider knows the service in question is noncovered by the carrier.<br>• Insurance failed to respond to initial and follow-up claim; or<br>• Benefits not assignable or cannot get an assignment. |

- 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:

| Code | Description |
|---|---|
| OI-P | PAID by HMO or HMP. The amount paid is indicated on the claim. |
| OI-H | HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount. |

*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. Services **covered** by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

**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 for covered services 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.

| Code | Description |
|---|---|
| M-1 | Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes and home health agencies when Medicare has made payment up to the lifetime limits of its coverage. |
| M-5 | Provider not Medicare certified for the benefits provided. |
| M-6 | Recipient not Medicare eligible. |
| M-7 | Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted. |
| M-8 | Medicare was not billed because Medicare never covers this service. |

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

**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 - I.D. NUMBER OF REFERRING PHYSICIAN**
When required, enter the referring provider's six- character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

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

**ELEMENT 19 - RESERVED FOR LOCAL USE**
If an unlisted procedure code is billed, providers must describe the procedure. If there is not enough space for the procedure 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** (not required)

**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 are billed using the same procedure code and modifier, if applicable.

-- 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 each procedure 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 place of service code "B" for each service.

**ELEMENT 24C - TYPE OF SERVICE CODE**
Enter type of service code "F" for each service.

**ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES**
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column.

**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 to 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 or 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. If the procedure is not an emergency, leave this element blank.

**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.

Any other information entered in this column may cause claim denial.

**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** (not required)