Medical Assistance Provider Bulletin

Attention: All Wisconsin Medical Assistance Program (WMAP) Certified Personal Care Providers

Subject: Claim Submission Limit for Disposable Medical Supplies

Date: November 1, 1993

Code: MAPB-093-024-L

Department of Health and Social Services, Division of Health,
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DOCUMENT SUMMARY

This document contains important information on a new claim submission limit for disposable medical supplies. This change takes effect January 1, 1994.

I. INTRODUCTION

This Medical Assistance Provider Bulletin (MAPB) provides important information on a new claims submission limit for disposable medical supplies. The effective date for this change is January 1, 1994.

II. CLAIM SUBMISSION FOR DISPOSABLE MEDICAL SUPPLIES

A. Introduction

This Medical Assistance Provider Bulletin (MAPB) provides important information on a new drug claim submission limit soon to be implemented by the Wisconsin Medical Assistance Program (WMAP). The claim submission limit is being implemented to reduce claims processing expenditures. This is being done by reducing the total volume of claims submitted to the WMAP. This reduction in expenditures is necessary due to a decrease in administrative funds available to the WMAP in the State 1993-95 budget. Similar claim submission limits are currently applied to nursing homes, which may only bill the WMAP once a month, and hospitals, which may only bill the WMAP after the recipient is discharged. The WMAP has additional claim reduction efforts in progress for other WMAP-certified providers.

In order to assist providers in efficiently implementing the claim submission limit, EDS' software is being updated to allow 25 details per electronic claim, instead of the 10 details currently accepted. The electronic claim format for batch transmission and tape submission will remain the same. The updated software will be available for providers by December 1, 1993. Providers will then have the option of testing the software.

Please review this information carefully and share it immediately with your billing staff or the billing service that submits your WMAP paper or electronic drug claims. A copy of this MAPB is also being sent to all WMAP electronic billers. Since most drug claims are submitted electronically, the WMAP has directly contacted the major vendors submitting drug claims to the WMAP about this change in policy.

Direct any questions concerning this MAPB to the EDS Correspondence Unit for Policy/Billing Information at 800-947-9627 or 608-221-9883.

B. Claim Submission Limit Policy

Effective with drug claims received by EDS on or after January 2, 1994, **all** disposable medical supplies dispensed to the **same recipient**, by the **same provider**, during the **same calendar week** (Sunday through Saturday), must be billed on the same claim.

All providers that bill these items, including pharmacies, durable medical equipment suppliers, and home health agencies, are required to submit drug claims according to the guidelines in this MAPB. This policy does not apply to services that are billed on other claim forms (e.g., personal care services which are billed on the UB-92).

Important Note: The WMAP encourages providers to bill products dispensed in different weeks on the same claim whenever possible. However, products dispensed in the same week may no longer be billed on different claims, except in the instances noted below.

Once a claim is paid by the WMAP, subsequent drug claims will be denied if they are for disposable medical supplies dispensed to the same recipient, by the same provider, for the same week as a previously paid claim. (The Explanation of Benefits [EOB] message will identify the paid claim.) Refer to Section II-F of this MAPB for information on provider follow-up to denied claims.

C. Exceptions to the Claim Submission Limit Policy

The only exceptions to the claim submission policy are:

- If more than six products are dispensed during a calendar week and the provider submits paper claims, then two or more paper claims may be submitted for a calendar week. (This is because there are only six detail lines on a paper claim.) However, if multiple paper claims are submitted during the same calendar week, each claim must have all six details completed except for the last claim submitted.

- If more than 25 products are dispensed during a calendar week and the provider submits electronic claims, then two or more electronic claims may be submitted for a calendar week. (This is because there are only 25 detail lines on an electronic claim.) However, if multiple electronic claims are submitted during the same calendar week, each claim must have all 25 details completed except for the last claim submitted.

- If the disposable medical supplies have been prior authorized with two or more prior authorization numbers, then two or more electronic or paper claims may be submitted for a calendar week.

- Paper claims with the variance check indicator "V-Y" ("Verified-Yes") in element 2 of the drug claim form, which are submitted when the quantity and charge amount of a denied detail are correct, are exempt from the claim submission limit.

D. Examples of the Claim Submission Limit Policy

The following examples illustrate how providers should bill their claims given the new billing limit policy.

Example 1: Paid Claim for Multiple Services, Same Calendar Week

A provider dispenses prescriptions for two disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Tuesday, January 4, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria. The provider must submit one paper or electronic claim with five details completed.

Example 2: Paid Claim for Multiple Services, Different Calendar Weeks

A provider dispenses prescriptions for five disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Wednesday, January 12, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria for the five disposable medical supplies, and the same recipient, same provider, same calendar week criteria for the three disposable medical supplies, but the services were provided in two different calendar weeks. Therefore, the provider may combine all services even though they were provided in different calendar weeks and submit one electronic claim, or the provider may submit one paper or electronic claim for the disposable medical supplies, and a second paper or electronic claim for the three disposable medical supplies, since the services were provided in different calendar weeks.

Example 3: Paid Claim for Multiple Services, Different Calendar Weeks

A provider dispenses prescriptions for three disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Wednesday, January 12, 1994, for the same recipient, and bills for all six products on one paper claim. Subsequently, the provider determines that he needs to bill for one more product for week one. The provider may submit an additional paper claim for the seventh product since all six details were used on the first claim, even though the claim was for products dispensed in different calendar weeks.

Example 4: Paid Claim for Prior Authorized and Non-Prior Authorized Services, Same Calendar Week

A provider dispenses a prior authorized disposable medical supplies product on Sunday, January 2, 1994, and a non-prior authorized disposable medical supplies product on Tuesday, January 4, 1994. This sequence of services qualifies as an exception to the requirement that services provided in the same calendar week must be billed on the same claim form. However, since only one service was prior authorized, the services must be combined and submitted as one claim to the WMAP.

Example 5: Denied Claim for Multiple Services, Same Calendar Week

A provider dispenses prescriptions for two disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Tuesday, January 4, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria. The provider submits one paper or electronic claim with five details completed. However, the provider transposes digits in the NDC for one of the disposable medical supplies and this detail denies. The provider finds the error, corrects it, and refiles the claim with the paid details crossed out. **This claim will be denied.** In order for the provider to be reimbursed for the denied detail, the provider must submit an adjustment to the original claim with the corrected NDC.

Example 6: Denied Claims for Multiple Services, Same Calendar Week

A provider dispenses prescriptions for two disposable medical supplies on Sunday, January 2, 1994, and four disposable medical supplies on Tuesday, January 4, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria. If the provider submits six separate claims, one claim will be processed and paid. However, the other five claims will be denied since all six services should have been submitted on the same claim form. In order for the provider to be reimbursed for the denied claims, the provider must submit an Adjustment Request Form and adjust the first paid claim to add the five denied services.

Example 7: Denied Claims for Multiple Services, Same Calendar Week

A provider dispenses five disposable medical supplies on Sunday, January 2, 1994, five disposable medical supplies on Tuesday, January 4, 1994, and three disposable medical supplies on Wednesday, January 5, 1994, to the same recipient. This sequence of services meets the same calendar week, same provider, same recipient criteria.

The provider should submit one electronic claim or three paper claims for the 13 services. If the provider submits one electronic claim for the five disposable medical supplies, a second electronic claim for the disposable medical supplies, and a third electronic claim for the disposable medical supplies, the second and third claims will be denied. In order for the provider to be reimbursed for the denied claims, the provider must submit an Adjustment Request Form and adjust the first paid claim.

E. Implementation Considerations for Claim Submission

The claim submission limit establishes, at a minimum, a drug claim billing period of no less than one week. If providers have already established a billing period longer than one week (e.g., monthly), the providers should continue their current billing practices. However, providers and billing services that submit claims should keep in mind that claim submission must be delayed until at least Sunday for claims from the entire previous calendar week (Sunday through Saturday). For providers that routinely submit claims to the WMAP on days other than Sunday, this will initially result in a one-week delay before claims may be submitted. Failure to delay claim submission until at least Sunday will result in denied claims and increased submission of adjustments in order to be reimbursed for charges not already submitted.

F. Provider Follow-Up

The provider must submit an Adjustment Request Form to EDS for reimbursement of services not billed on the original claim, or for reimbursement of denied details on a partially paid claim. With partially paid claims, providers may no longer simply find the billing error, correct it, and resubmit the claim with the paid details crossed out. Providers are reminded that claims which are totally denied must be corrected and resubmitted for payment. An Adjustment Request form must not be submitted for a totally denied claim. This claim will be denied. Refer to Appendices 27 and 27a of Part A of the WMAP Provider Handbook for information on submitting an Adjustment Request Form.