Physician Services

Laboratory and Radiology

ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

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Preface

This Physician Services Handbook is issued to all Medicaid-certified physician services providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of the All-Provider Handbook for information about state-contracted managed care organizations.

Handbook Organization

This Physician Services Handbook consists of the following sections:

- Anesthesia.
- Laboratory and Radiology.
- Medicine and Surgery.

All-Provider Handbook

All Medicaid-certified providers receive a copy of the All-Provider Handbook, which includes the following sections:

- Certification and Ongoing Responsibilities.
- Claims Information.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Informational Resources.
- Managed Care.
- Prior Authorization.
- Recipient Eligibility.

Providers are required to refer to the All-Provider Handbook for information about these topics.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/.*
- *dhfs.wisconsin.gov/badgercare/.*

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).

- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

General Information

The Laboratory and Radiology section of the Physician Services Handbook includes information for physicians, physician assistants, physician clinics, nurse practitioners, and nurse midwives performing laboratory and radiology services. This section includes information regarding covered services, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers.

It is essential that providers refer to the All-Provider Handbook for general information about certification, provider rights, documentation requirements, and other ongoing responsibilities.

Certification

To be certified by Wisconsin Medicaid, physicians are required to be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

Physicians are asked to identify their practice specialty at the time of Medicaid certification. Reimbursement for certain services is limited to physicians with specific specialties.

Provider Numbers

Wisconsin Medicaid issues billing performing, group billing, and nonbilling performing provider numbers to physician pathology and radiology services providers. Those physician pathology and radiology providers who are issued group billing numbers are not required to indicate a performing provider number on claims. Refer to the Medicine and Surgery section of this handbook for more information about provider numbers.

Recipient Copayment

Wisconsin Medicaid requires providers to collect copayment from recipients for certain services. Providers are required to make a reasonable attempt to collect the copayment unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Certain groups of recipients and certain Medicaid-covered services are exempt from copayments. In addition, copayments are exempt for technical and professional components of diagnostic tests when the service is not billed as a global procedure. Refer to the Recipient Eligibility section of the All-Provider Handbook for more information about exemptions and other information about copayments.

Copayment for Physician Laboratory and Radiology Services

The copayment amount for each laboratory service is $1.00 per test. The copayment amount for each radiology service is $3.00 per procedure.

A recipient's copayment for physician services is limited to $30.00 cumulative, per physician ***or*** clinic (using a group billing number), per calendar year.

Abortions

Coverage Policy

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.
2. In a case of sexual assault or incest, provided that prior to the abortion the

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physician attests to his or her belief that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the law enforcement authorities.

3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Anesthesia services.
- Laboratory testing and interpretation.
- Recovery room services.
- Transportation.
- Routine follow-up visits.
- Ultrasound services.

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid.

Laboratory Services

Physician Laboratory Definition and Certification Criteria

Wisconsin Medicaid defines a physician office laboratory as a laboratory that is maintained by a physician or clinic for performing diagnostic tests for the patients of the physician or clinic. A physician office laboratory may perform laboratory services when the following conditions are met:

- The performing provider, such as the supervising physician, is a Medicaid-certified provider.
- The laboratory provider has a current, verified, unrevoked, and not suspended Clinical Laboratory Improvement Amendment (CLIA) certificate or CLIA waiver.

Wisconsin Medicaid defines a physician office laboratory as a laboratory that is maintained by a physician or clinic for performing diagnostic tests for the patients of the physician or clinic.

Independent Laboratories

Medicaid-certified independent laboratories, are required to meet the following requirements:

- The laboratory must be Medicare certified.
- The laboratory must have a current, verified, unrevoked, and not suspended CLIA certificate or CLIA waiver.
- The laboratory's services and office facilities must be available to other physicians for performing diagnostic tests.

Independent laboratories should refer to the Independent Labs page of the Medicaid Web site for more information. Providers without Internet access may call Provider Services at (800) 947-9627 or (608) 221-9883.

Clinical Certification for Laboratory Services — CLIA

Congress implemented the CLIA to improve the quality and safety of laboratory services. CLIA requires ***all*** laboratories and providers performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards.

CLIA Enrollment

The federal Centers for Medicare and Medicaid Services (CMS) sends CLIA enrollment information to Wisconsin Medicaid. The enrollment information includes CLIA identification numbers for all current laboratory sites. Wisconsin Medicaid verifies that laboratories are CLIA-certified before issuing a Medicaid provider billing number.

CLIA Regulations

Wisconsin Medicaid complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988.
- Title 42 CFR Part 493, Laboratory Requirements.

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.

- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.
- Test methods, equipment, instrumentation, reagents, materials, supplies.
- Tests performed.

CLIA regulations apply to *all* Medicaid providers who perform laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Nurse midwives.
- Nurse practitioners.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Physician groups with a single Medicaid group billing number, but multiple CLIA numbers for different laboratories, may wish to contact Provider Services to discuss various certification options. The CMS issues five types of certificates for laboratories:

1. *Waiver certificate*. This certificate allows a laboratory to perform waived tests only. Refer to the CMS Web site at *www.cms.hhs.gov/clia/waivetbl.pdf* for the most current list of waived procedures. Refer to the physician services maximum allowable fee schedule for Medicaid-allowable waived procedures.
2. *Provider-performed microscopy procedures certificate*. This certificate allows a physician, mid-level practitioner (i.e., nurse midwife, nurse practitioner, or physician assistant licensed by the state of Wisconsin), or dentist to perform microscopy and waived procedures only. Refer to the CMS Web site at *www.cms.hhs.gov/clia/ppmplst.asp* for the most current list of CLIA-allowable provider-performed microscopy procedures. Refer to the physician fee schedule for Medicaid-allowable provider-performed microscopy procedures.
3. *Registration certificate*. This certificate allows a laboratory to conduct moderate- or high-complexity tests until the laboratory is determined to be in compliance through a CMS survey performed by the Wisconsin state agency for CLIA.
4. *Compliance certificate*. This certificate is issued to a laboratory (for moderate- and/or high-complexity tests) after a CMS inspection performed by the state agency finds the laboratory in compliance with all applicable complexity-level requirements.
5. *Accreditation certificate*. This certificate is issued on the basis of the laboratory's accreditation by a CMS-approved accreditation organization. The six major approved accreditation organizations are:
   - ✓ Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
   - ✓ College of American Pathologists (CAP).
   - ✓ COLA.
   - ✓ American Osteopathic Association.
   - ✓ American Association of Blood Banks.
   - ✓ American Society of Histocompatibility and Immunogenetics (ASHI).

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers may obtain CMS 116 forms from the CMS Web site at *www.cms.hhs.gov/* or from the following address:

Bureau of Quality Assurance
Division of Disability and Elderly Services
Clinical Laboratory Unit
Ste 300
2917 International La
Madison WI 53704

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Providers Required to Report Changes

Providers are required to notify the Clinical Laboratory Unit in writing within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify the Clinical Laboratory Unit of changes in certificate types immediately and within six months when a specialty/subspecialty is added or deleted. Providers may reach the Clinical Laboratory Unit at (608) 243-2023.

Procedure Codes and Modifiers

Covered physician laboratory services are identified by the *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes listed in Appendix 1 of this section. Appendix 3 includes a list of allowable modifier descriptions for physician laboratory services.

Covered physician laboratory services are identified by the *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes listed in Appendix 1 of this section.

Wisconsin Medicaid coverage of laboratory services is based on the procedure performed by the physician or his or her designee and is identified by the procedure code that best describes the procedure performed.

Procedures on claims submitted by laboratories must be appropriate for the CLIA certification type indicated in the billing provider's Medicaid file. Providers are required to use the most current fee schedule in conjunction with the most current CPT and HCPCS procedure code references to determine coverage of services.

Category III Codes

Wisconsin Medicaid covers a limited number of services identified by Category III Emerging Technology CPT codes. Category III codes are temporary codes for emerging technology, services, and procedures. Category III codes consist of four numbers followed by the letter "T." Providers should refer to the physician fee schedule for allowable Category III codes.

Place of Service Codes

Providers are required to indicate two-digit place of service (POS) codes on claims and other forms submitted to Wisconsin Medicaid. Refer to Appendix 4 of this section for allowable POS codes for physician laboratory services.

Laboratory Consultations

Physicians may be reimbursed for laboratory consultations only when the consultation is medically necessary and appropriate for the recipient's treatment. Laboratory consultations are reimbursable only when performed at the request of the attending physician and when the results are contained in a written report that becomes part of the recipient's medical record.

The referring physician's name and provider number must be indicated on the claim.

Multiple Laboratory Tests

Multiple laboratory tests must be billed with a panel or aggregate procedure code (e.g., hemogram) when such a code exists in CPT. This policy is monitored by Wisconsin Medicaid's claim review system, McKesson ClaimCheck®. Refer to the Claims Submission and Reimbursement chapter of this section for more information about ClaimCheck.

Total reimbursement for multiple chemistry or other laboratory tests billed individually may not exceed the reimbursement rate established by Wisconsin Medicaid for the most closely related panel or aggregate code. The provider's reimbursement may be corrected on a post-payment basis by Wisconsin Medicaid.

For example, an electrolyte panel (procedure code 80051) must include the following tests:

- Carbon dioxide (82374).
- Chloride (82435).
- Potassium (84132).
- Sodium (84295).

If a provider performs only three of the above tests, each code must be indicated separately on a claim and each will be reimbursed as a separate procedure. However, Wisconsin Medicaid may later reconsider the reimbursement and adjust it to equal the reimbursement rate for the electrolyte panel.

Urinalysis

When two or more of the services listed in the urinalysis section of CPT are performed on the same day for the same recipient by the same provider with a POS code other than "21" (inpatient hospital) or "22" (outpatient hospital), they are reimbursed collectively at no more than the maximum fee amount for procedure code 81000 (Urinalysis, by dip stick or tablet reagent ... non-automated, with microscopy).

Routine urinalysis is included in the reimbursement for antepartum care and is not separately reimbursable. Refer to the Medicine and Surgery section of this handbook for more information on obstetric services coverage.

Complete Procedure Versus Professional and Technical Components

Most laboratory services are performed and reimbursed as a complete procedure. A relatively small number of laboratory procedure codes have technical (modifier "TC") and professional (modifier "26") components. Nevertheless, these procedures may be billed as a complete procedure when both the technical and professional components are performed by a single laboratory. A *written report* must be produced and maintained in the recipient's medical record when one of these procedure codes (having technical and professional components) is billed with either modifier "26" or no modifier at all.

At times the technical component is performed by the physician clinic but the professional component is performed by an outside physician or laboratory. In this situation, each provider may be reimbursed only for the service performed, as follows:

- The provider performing the technical component may be reimbursed only for the technical component (modifier "TC").
- The provider performing the professional component may be reimbursed only for the professional component (modifier "26"). (The professional component must result in a written report that is kept in the recipient's medical record.)

The complete procedure is not reimbursable to either provider in this situation.

The attending physician's clinical interpretation of laboratory results is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician-recipient encounter (i.e., the evaluation and management service). However, the attending physician may be paid the clinical interpretation of a laboratory test if the attending physician is the sole provider of the professional component.

Laboratory Test Preparation and Handling Fees

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure. The physician who forwards the specimen is only reimbursed a handling fee.

When forwarding a specimen from a physician's office to an outside laboratory, submit claims for preparation and handling fees

M Most laboratory services are performed and reimbursed as a complete procedure.

using procedure code 99000. When forwarding a specimen from someplace other than a physician's office to a laboratory, submit claims using procedure code 99001. It is not necessary to indicate the specific laboratory test performed on the claim.

A handling fee is not reimbursable if the physician is reimbursed for the professional and/or technical component of the laboratory test.

Wisconsin Medicaid recommends that providers send laboratory specimens to Medicaid-certified laboratories.

Additional Limitations

Additional limitations on reimbursement for handling fees are:

1. One lab handling fee is reimbursed to a physician per recipient, per outside laboratory, per date of service (DOS), regardless of the number of specimens sent to the laboratory.
2. More than one handling fee is reimbursed when specimens are sent to two or more laboratories for one recipient on the same DOS. Indicate the number of laboratories and the total charges on the claim. The name of the laboratory does not need to be indicated on the claim; however, this information must be documented in the provider's records.
3. The DOS must be the date the specimen is obtained from the recipient.

Hospital-Based Laboratory Services

Wisconsin Medicaid reimburses physicians in the hospital setting, inpatient or outpatient, for the professional component only for those procedure codes listed with modifier "26" in Appendix 1 of this section. A written report of the analysis and interpretation of the laboratory test results, which must be maintained in the recipient's medical record, is required for reimbursement of the professional component.

The technical component is paid to the hospital according to the hospital's usual Medicaid reimbursement method. Pathologists or other physicians who perform the professional component are required to submit claims independently from the hospital.

Services Purchased from Outside Laboratory

Wisconsin Medicaid recommends that providers send laboratory specimens to Medicaid-certified laboratories. Occasionally, a laboratory providing unique or specialized laboratory services (e.g., genetic tests), is out-of-state or does not accept Medicaid reimbursement. In this case, a physician laboratory may send a specimen to an outside laboratory that is *not* Medicaid certified with which there is a contractual agreement. The physician laboratory may then submit claims for the laboratory services, including the professional and/or technical components, performed by the outside laboratory, consistent with HFS 106.03(5)(a)2, Wis. Admin. Code.

If the outside laboratory *is* Medicaid certified, the outside laboratory is required to submit claims for the services, not the physician laboratory.

When a physician laboratory sends specimens to a non-Medicaid-certified laboratory, the provider is required to use the amount charged by the outside laboratory as the billed amount on the claim submitted to Wisconsin Medicaid.

Newborn Screenings

Providers are required to test newborns for certain congenital and metabolic disorders, per s. 253.13, Wis. Stats. These tests require a prepaid filter paper card purchased from the State Laboratory of Hygiene. Wisconsin Medicaid reimburses providers for purchasing the prepaid filter paper cards and the laboratory handling fee for newborn screenings performed outside a hospital setting.

Coverage and Reimbursement Procedures

The following is a list of the CPT codes with allowable POS codes and instructions for submitting paper claims to Wisconsin Medicaid

for Medicaid-covered newborn screening services:

- *86849* (Unlisted immunology procedure).
  - ✓ Wisconsin Medicaid reimburses this procedure code for prepaid filter paper cards purchased from the State Laboratory of Hygiene.
  - ✓ This procedure code is allowable in POS "11" (office) or POS "12" (home).
  - ✓ In Element 19 of the CMS 1500 claim form, enter "Newborn screening state lab card" or attach documentation to a paper claim to indicate the claim is for a prepaid filter paper card for newborn screening purchased from the Wisconsin State Laboratory of Hygiene.
- *99000* (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory).
  - ✓ Wisconsin Medicaid reimburses this procedure code for the transfer of the specimen from the physician's office to the State Laboratory of Hygiene.
  - ✓ Indicate a quantity of 1.0 since the specimen is going to only one lab.
- *99001* (Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory).
  - ✓ Wisconsin Medicaid covers this procedure code for the transfer of the specimen from a location other than a physician's office to the State Laboratory of Hygiene.
  - ✓ Indicate a quantity of 1.0 since the specimen is going to only one lab.

Routine Venipuncture

Routine venipuncture or simple blood collection (e.g., through heel or finger stick) is not separately reimbursable but is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. The recipient may not be billed for routine venipuncture.

Noncovered Laboratory Services

Laboratory services that are not medically necessary are not covered services under Wisconsin Medicaid. This includes, but is not limited to, the following services:

- Services to enhance the prospects of fertility.
- Services that are experimental in nature.
- Services that do not have FDA or Wisconsin Medicaid approval.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about services *not covered* by Wisconsin Medicaid.

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Routine venipuncture or simple blood collection (e.g., through heel or finger stick) is not separately reimbursable but is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee.

Radiology Services

Procedure Codes and Modifiers

Wisconsin Medicaid coverage of diagnostic imaging, therapeutic radiology, and nuclear medicine services is based on the procedure code that best describes the procedure performed.

Covered radiology services are identified by the *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes listed in Appendix 2 of this section. Appendix 3 of this section includes allowable modifier descriptions for physician radiology services.

Wisconsin Medicaid coverage of diagnostic imaging, therapeutic radiology, and nuclear medicine services is based on the procedure code that best describes the procedure performed.

Wisconsin Medicaid covers only those radiologic services actually performed by or under the professional supervision of the physician. Wisconsin Medicaid separately reimburses for diagnostic imaging agents (e.g., low osmolar contrast material), radiopharmaceutical diagnostic agents (e.g., technetium), and other contrast media used in conjunction with radiological services. Wisconsin Medicaid does not separately reimburse the venipuncture associated with administration of these materials.

Place of Service Codes

Providers are required to indicate two-digit place of service (POS) codes on claims and other forms submitted to Wisconsin Medicaid. Refer to Appendix 4 of this section for allowable POS codes for radiology services.

Complete Radiologic Procedure Versus Professional and Technical Components

A physician or physician clinic may be reimbursed for the "complete" (total) procedure when performing both the professional (modifier "26") and technical (modifier "TC") components, or supervising others who do so in the office, clinic, or other non-hospital setting.

Radiologic procedure codes also have technical and professional components that are separately reimbursable. Refer to Appendix 2 of this section for the appropriate procedure codes and applicable modifiers.

A *written report* regarding the analysis and interpretation of the radiologic test results is required for Wisconsin Medicaid reimbursement of the professional component. The written report must be kept as part of the recipient's medical record.

If the POS is a hospital setting (inpatient, POS code "21," or outpatient, POS code "22") or if the technical portion is performed by a portable X-ray provider, a physician may be reimbursed only for the professional component, not for the complete procedure. The technical component is reimbursed to the hospital or provider of portable X-ray services.

Physician clinics that perform only the technical component of radiologic services are reimbursed by Wisconsin Medicaid only for the technical component. The outside physician performing the professional component of the service is reimbursed only for the professional component.

The attending physician's clinical interpretation of radiology services is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician-recipient encounter (i.e., the evaluation and management service).

Consultations

Wisconsin Medicaid reimburses physicians for radiology consultations only when medically necessary and appropriate for the recipient's treatment. Radiology consultations are reimbursable only when performed at the request of the attending physician and the results are contained in a written report, which is maintained in the recipient's medical record.

Radiological Supervision and Interpretation by Providers Who Are Not Radiologists

Radiological supervision and interpretation services are provided nearly exclusively by radiologists. Providers who are not radiologists are urged to use caution in billing such services to avoid duplicate billing with radiologists.

Hospital-Based Radiology Services

Wisconsin Medicaid reimburses hospitals for the technical component of a radiology service. The professional component is not included in the hospital's reimbursement. Therefore, physicians with a specialty of radiology or nuclear medicine who perform the professional component are required to submit claims independently from the hospital.

Radiology consultations are reimbursable only when performed at the request of the attending physician and the results are contained in a written report, which is maintained in the recipient's medical record.

Claims Submission and Reimbursement

All claims that providers submit, whether submitted using the 837 Health Care Claim: Professional (837P) transaction or paper claim, are subject to the same Medicaid processing and legal requirements.

This chapter includes billing and reimbursement information for physician services providers. For more information about exceptions to the claims submission deadline, Medicaid remittance information, adjustment requests, and returning overpayments, refer to the Claims Information section of the All-Provider Handbook.

To receive reimbursement, claims and adjustment requests must be received by Wisconsin Medicaid within 365 days of the date of service (DOS). To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received by Wisconsin Medicaid within 365 days of the DOS, or within 90 days of the Medicare processing date, whichever is later.

All claims that providers submit, whether submitted using the 837 Health Care Claim: Professional (837P) transaction or paper claim, are subject to the same Medicaid processing and legal requirements.

837 Health Care Claim: Professional

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for physician services may be submitted using the 837P transaction *except* when billing an "unlisted" (nonspecific) procedure code or when supporting documentation must be submitted with the claim.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

CMS 1500

Paper claims for physician services must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for physician services submitted on any paper claim form other than the CMS 1500 claim form. A paper claim must be submitted when billing for an "unlisted" (nonspecific) procedure code(s) or when supporting documentation must be submitted with the claim. An example of physician laboratory services that must be submitted on the CMS 1500 paper claim include newborn screening services.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Refer to Appendix 5 of this section for CMS 1500 claim form completion instructions. Refer to Appendices 6 and 7 of this section for sample completed CMS 1500 claim forms for laboratory and radiology services.

Unlisted Procedures

Claims for services identified by unlisted (nonspecific) procedure codes must be submitted on paper because a national standard for electronic claim attachments has not been established at this time. To receive reimbursement for a service identified by an unlisted procedure code, a description of the service must be indicated in Element 19 of the paper claim. If Element 19 does not provide enough space for the description, or if a provider is billing multiple unlisted procedure codes, documentation may be attached to the claim. In this instance, the provider should indicate "see attachment" in Element 19.

The description in Element 19 or the documentation attached to the claim must be

sufficient to allow Wisconsin Medicaid to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in Wisconsin Administrative Code.

Providers should submit claims for new laboratory tests that have not received a *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code as an unlisted procedure. Wisconsin Medicaid typically only covers tests that are approved by the federal Food and Drug Administration.

Reimbursement

Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. (Wisconsin Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee for the procedure.) Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted to Wisconsin Medicaid, the Wisconsin State Legislature's budgetary constraints, and other relevant economic limitations.

Maximum allowable fees for each laboratory and radiology service is equal to or less than the amount allowed by Medicare as required by the federal Deficit Reduction Act (Section 2303 of the federal Deficit Reduction Act [DEFRA — P.L. 98-369]).

The Physician/Independent Lab/X-Ray/Nurse Practitioners/Physician Assistant Maximum Allowable Fee Schedule may be obtained as:

- An electronic version available on the Medicaid Web site.
- A paper copy that may be purchased by:
  - ✓ Calling Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.
  - ✓ Writing to the following address:

    Wisconsin Medicaid
    Provider Maintenance
    6406 Bridge Rd
    Madison WI 53784-0006

Maximum Daily Reimbursement

A provider's reimbursement for all services performed on the same DOS for the same recipient may not exceed the amount established by Wisconsin Medicaid, except for services lasting over six hours. As of July 1, 2002, the maximum daily amount is $2,308.43. Medicaid remittance information will indicate when the maximum daily reimbursement amount has been met.

A service exceeding six hours must first be billed to Wisconsin Medicaid in the usual manner. After the reimbursement is received, additional reimbursement may be requested by submitting an Adjustment/Reconsideration Request, HCF 13046, with clinical documentation to Wisconsin Medicaid. The completion instructions and Adjustment/Reconsideration Request are available on the Forms page of the Medicaid Web site.

ClaimCheck Review

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims

Maximum allowable fees for each laboratory and radiology service is equal to or less than the amount allowed by Medicare as required by the federal Deficit Reduction Act (Section 2303 of the federal Deficit Reduction Act [DEFRA — P.L. 98-369]).

submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to CPT procedure codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code.

ClaimCheck monitors the following Medicaid policy areas:

1. *Unbundling (Code Splitting)*
Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. ClaimCheck considers the single, most appropriate code for reimbursement when unbundling is detected.

   For example, if a provider submits a claim for certain laboratory tests separately, ClaimCheck rebundles them into the single, most appropriate panel (e.g., obstetric panel [80055] or hepatic function panel [80076]). ClaimCheck totals billed amounts for individual procedures. For example, if a provider submits a claim for three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. However, Wisconsin Medicaid reimburses the provider either the lesser of the billed amount or the maximum allowable fee for that procedure code.

2. *Incidental/Integral Procedures*
Incidental/integral procedures are those procedures performed as part of or at the same time as a more complex primary procedure. They require few additional physician resources and are generally not considered necessary to the performance of the primary procedure. For example, a radiologic examination, spine, single view, specify level (procedure code 72020) is incidental to a radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies (procedure code 72052).

   When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

3. *Mutually Exclusive Procedures*
Mutually exclusive procedures are procedures that would not be performed on a single recipient during the same operative session or that use different codes to describe the same type of procedure. For example, a radiologic examination, shoulder; one view (procedure code 73020) and radiologic examination, shoulder; complete, minimum of two views (procedure code 73030) are mutually exclusive — either one or the other procedure is performed, but not both.

   When two or more procedures are mutually exclusive, Wisconsin Medicaid reimburses the procedure code with the highest provider-billed amount.

Why Was Payment for a Service Denied by ClaimCheck?

Providers should take the following steps if they are uncertain about why particular services on a claim were denied:

1. Review Medicaid remittance information for the specific reason for the denial.
2. Review the claim submitted to ensure all information is accurate and complete.
3. Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
4. Consult this handbook and other current Wisconsin Medicaid publications to make

sure current policy and billing instructions were followed.

5. Contact Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 for further information or explanation.
6. If circumstances warrant an exception, submit an Adjustment Reconsideration/ Request with supporting documentation and the words "medical consultant review requested" written on the form.

Abortions, Hysterectomies, and Sterilizations

Wisconsin Medicaid requires surgeons to attach specific documentation to their claim when billing for an abortion, a hysterectomy, or a sterilization procedure. If the surgeon does not attach the required documentation, the surgeon's claim and *all* other claims directly related to the surgery are denied reimbursement. This includes a physician's laboratory or radiology claim. Therefore, verify with the surgeon's office that the surgeon has obtained the necessary documentation *before* the surgery is performed.

For more information about Wisconsin Medicaid's requirements for reimbursing abortion, hysterectomy, and sterilization claims, refer to the Medicine and Surgery section of this handbook.

Appendix

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Appendix 1

Allowable Procedure Codes and Modifiers for Physician Laboratory Services

The following table includes allowable *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes and modifiers for physician laboratory services. These codes are updated on a quarterly basis. Consult the physician services maximum allowable fee schedule or call Provider Services at (800) 947-9627 or (608) 221-9883 for the most current procedure codes and allowable modifier combinations. Refer to Appendix 3 of this section for modifier descriptions and the Medicine and Surgery section of this handbook for Health Professional Shortage Area-eligible procedure codes and ZIP codes.

Pathology and Laboratory Services		
Service	**CPT Procedure Code(s)**	**Allowable Modifier(s)**
Organ or Disease Oriented Panels	80048-80076	
Drug Testing	80100-80103	
Therapeutic Drug Assays	80150-80299	
Evocative/Suppression Testing	80400-80440	
Consultations	80500-80502	
Urinalysis	81000-81099	
Chemistry	82000-83018	
	83020-83021	TC, 26
	83026-83690	
	83715-83716	TC, 26
	83718-83785	
	83788-83789	TC, 26
	83805-83906	
	83912	26
	83915-84160	
	84165-84182	TC, 26
	84202-84999	
Hematology and Coagulation	85002-85048	
	85055-85060	TC, 26
	85097	
	85130-85385	
	85390	TC, 26
	85400-85557	
	85576	TC, 26
	85597-85999	
Immunology	86000-86243	
	86255-86256	TC, 26
	86277-86318	
	86320-86334	TC, 26
	86336-86849	

Pathology and Laboratory Services (Continued)		
Service	**CPT Procedure Code(s)**	**Allowable Modifier(s)**
Transfusion Medicine	86850-86999	
Microbiology	87001-87158	
	87164-87166	TC, 26
	87168-87206	
	87207	TC, 26
	87210-87904	
	87999	TC, 26
Cytopathology	88104-88125	TC, 26
	88130-88155	
	88160-88162	TC, 26
	88164-88167	
	88172-88182	TC, 26
	88184-88189	
	88199	TC, 26
Cytogenetic Studies	88230-88289	
	88291	26
	88299	TC, 26
Surgical Pathology	88300-88319	TC, 26
	88321-88329	
	88331-88399	TC, 26
Transcutaneous Procedures	88400	
Other Procedures	89050-89261	
	89264	TC, 26
	89300-89321	
Laboratory Handling Fees	99000-99001	

Service	HCPCS Procedure Codes	Allowable Modifier(s)
Procedures and Professional Services	G0103, G0107, G0123-G0124, G0141-G0148	
Pathology and Laboratory	P2028-P3001, P9010-P9044, P9045-P9050, P9615	
Temporary Codes	Q0091, Q0111-Q0115	
Private Payer Codes	S3708	TC, 26

Appendix 2

Allowable Procedure Codes and Modifiers for Physician Radiology Services

The following table includes allowable *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes and modifiers for physician radiology services. These codes are updated on a quarterly basis. Consult the physician services maximum allowable fee schedule or call Provider Services at (800) 947-9627 or (608) 221-9883, for the most current procedure codes and allowable modifier combinations. Refer to Appendix 3 of this section for modifier descriptions and the Medicine and Surgery section of this handbook for Health Professional Shortage Area-eligible procedure codes and ZIP codes.

Radiology Services		
Service	**CPT Procedure Code(s)**	**Allowable Modifier(s)**
Diagnostic Radiology (Diagnostic Imaging)	70010-70553	TC, 26
	70557-70559	
	75952-75954	26
	75960-76010	TC, 26
	76012-76013	26
	76020-76125	TC, 26
	76140-76350	
	76355-76400	TC, 26
Diagnostic Ultrasound	76506-76999	TC, 26
Radiation Oncology	77261-77263	26
	77280-77334	TC, 26
	77336-77370	
	77399	TC, 26
	77401-77432	
	77470-77799	TC, 26
Nuclear Medicine	78000-78891, 78999-79440, 79999	TC, 26

Service	**HCPCS Procedure Codes**	**Allowable Modifier(s)**
Radiopharmaceutical Contrast Media	A4641, A4644-A4647, A9500-A9505, A9508-A9510, A9600, A9700	
Procedures/Professional Services	G0030-G0047, G0125-G0130, G0173, G0204-G0230	TC, 26
	G0231-G0234	26
	G0242-G0243, G0251-G0254, G0296	TC, 26
Radiopharmaceutical Temporary Codes	Q3001-Q3012	
Radiopharmaceutical Injections	Q9941-Q9964	
Private Payer Codes	S8030, S8035-S8040, S8049, S8080-S8092, S9022-S9024	TC, 26

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Appendix 3

Allowable Modifiers for Physician Laboratory and Radiology Services

Wisconsin Medicaid accepts nationally recognized modifiers on claims and other forms, when applicable. The following table lists Medicaid-allowable modifiers for physician laboratory and radiology services.

Note: Wisconsin Medicaid accepts all valid modifiers, however, not all modifiers are allowed by Wisconsin Medicaid's claims processing system.

Modifier	Description
26	Professional component
AQ	Physician providing service in a HPSA
QW	CLIA waived test
TC	Technical component

*Providers receive enhanced reimbursement when services are performed in a Health Professional Shortage Area (HPSA). Refer to the Medicine and Surgery section of this handbook for HPSA-eligible procedures.

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Appendix 4

Allowable Place of Service Codes for Physician Laboratory and Radiology Services

Providers are required to indicate two-digit place of service (POS) codes on claims submitted to Wisconsin Medicaid. The following table lists Medicaid-allowable POS codes that providers are required to use when submitting claims for physician laboratory and radiology services.

Place of Service Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12*	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34*	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

*Place of service code applicable for laboratory services only.

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Appendix 5

CMS 1500 Claim Form Instructions for Physician Services

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

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) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

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

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation 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 or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO 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 was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that 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

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Physicians are required to be Medicare enrolled to provide Medicare-covered services for dual eligibles. Dual eligibles are those recipients covered under both Medicare and Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

Appendix 5
(Continued)

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** *(Not applicable to physicians)* This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Elements 12 and 13 — Authorized Person's Signature (not required)

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)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (required for evaluation and management consultations and laboratory and radiology services only)

Enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Family Planning Services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are contraceptive management-related only.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required for laboratory or radiology services)

Element 24A — Date(s) of Service

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

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing *only* the date(s) of the month. For example, for DOS on December 1, 8, 15, and 22, 2004, indicate 12/01/04 or 12/01/2004 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge *per detail line* in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Appendix 5
(Continued)

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Appendix 4 of this section for allowable POS codes for physician laboratory and radiology services.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Note: Wisconsin Medicaid has not adopted all national modifiers. Refer to Appendices 1 and 2 of this section for allowable procedure code and modifier combinations for physician laboratory and radiology services. Refer to Appendix 3 for modifier descriptions.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan

Enter an "F" for each family planning procedure. If family planning does not apply, leave this element blank.

Element 24I — EMG

Enter an "E" for *each* procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If a dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting 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 or MM/DD/YYYY format.

Note: The signature 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 Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, Zip Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 6

Sample CMS 1500 Claim Form for Physician Laboratory Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [P] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

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: MM DD YY SEX M [ ] F [X]

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 [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V79.9
2. V18.3
3. ____
4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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 EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 19 04		11		85576	26	1	XX XX	1.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $ XX XX

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.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555

PIN# 87654321 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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Appendix 7

Sample CMS 1500 Claim Form for Physician Radiology Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [P] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

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: MM DD YY SEX M [ ] F [X]

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 [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Physician

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 959.09 3. ____ 2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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 EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 18 04		11		70100	26	1	XX XX	1.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $ XX XX

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

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

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