#### Contacting Wisconsin Medicaid

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

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.
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
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.
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.

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 CLIA-allowable waived tests. 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 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
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.

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.
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.

**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.
Radiology Services

Procedure Codes and Modifiers

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.
Claims Submission and Reimbursement

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:

- 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.

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.

**Abortion, 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 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.

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<th>Service</th>
<th>CPT Procedure Code(s)</th>
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<tbody>
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<td>Drug Testing</td>
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<td>Therapeutic Drug Assays</td>
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<td>Evocative/Suppression Testing</td>
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<td>Consultations</td>
<td>80500-80502</td>
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<td>Urinalysis</td>
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<td>Hematology and Coagulation</td>
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## Pathology and Laboratory Services (Continued)

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<td>Pathology and Laboratory</td>
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<td>Temporary Codes</td>
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<td>Private Payer Codes</td>
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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.

<table>
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<tr>
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<td>Diagnostic Radiology</td>
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<td>(Diagnostic Imaging)</td>
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<td>76355-76400</td>
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<td>Diagnostic Ultrasound</td>
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<td>Radiation Oncology</td>
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<td>Nuclear Medicine</td>
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<td>Radiopharmaceutical Contrast Media</td>
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<td>Procedures/Professional Services</td>
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<td>G0242-G0243, G0251-G0254, G0296</td>
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<tr>
<td>Radiopharmaceutical Temporary Codes</td>
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<td>Radiopharmaceutical Injections</td>
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<td>Private Payer Codes</td>
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<td>TC, 26</td>
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</table>
ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy
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.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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<tbody>
<tr>
<td>26</td>
<td>Professional component</td>
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<tr>
<td>AQ</td>
<td>Physician providing service in a HPSA</td>
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<tr>
<td>QW</td>
<td>CLIA waived test</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
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</table>

*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.*

ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy
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.

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

*Place of service code applicable for laboratory services only.
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.
Appendix 5
(Continued)

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.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>OI-P</td>
<td>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.</td>
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<tr>
<td>OI-D</td>
<td>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.</td>
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</tbody>
</table>
| 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:

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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</table>
| 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)*
Appendix 5  
(Continued)

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)
Appendix 5
(Continued)

**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**

![Sample CMS 1500 Claim Form](image)

**Physician Services Handbook — Laboratory and Radiology ▶ December 2005**
ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy
### Appendix 7

Sample CMS 1500 Claim Form for Physician Radiology Services

**HEALTH INSURANCE CLAIM FORM**

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<tr>
<th><strong>A. MEDICARE</strong></th>
<th><strong>B. MEDICAID</strong></th>
<th><strong>C. CHAMPUS</strong></th>
<th><strong>D. CHAMPSA</strong></th>
<th><strong>E. GROUP HEALTH PLAN</strong></th>
<th><strong>F. FECA</strong></th>
<th><strong>G. BLX LUNG</strong></th>
<th><strong>H. SSN</strong></th>
<th><strong>I. ID NUMBER</strong></th>
<th><strong>J. FOR PROGRAM IN ITEM 1</strong></th>
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<td><strong>1.</strong> Medicare Number</td>
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<td><strong>2.</strong> Medicare X</td>
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<td><strong>4.</strong> Recipient's Address (City, Street)</td>
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<td><strong>8.</strong> Recipient's Telephone Number</td>
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<td><strong>9.</strong> Recipient's Date of Birth</td>
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<td><strong>10.</strong> Recipient's Sex</td>
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<td><strong>11.</strong> Recipient's Relationship to Insured</td>
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<td><strong>14.</strong> Insured's Address (City, Street)</td>
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<td><strong>15.</strong> Insured's City</td>
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<td><strong>16.</strong> Insured's State</td>
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<td><strong>17.</strong> Insured's Zip Code</td>
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<td><strong>20.</strong> Insured's Sex</td>
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<td><strong>21.</strong> Insured's Relationship to Recipient</td>
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<td><strong>29.</strong> Insured's Date of Birth</td>
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<td><strong>31.</strong> Insured's Relationship to Recipient</td>
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<td><strong>33.</strong> Insured's Relationship to Recipient</td>
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**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**12.** Physician's or Authorizing Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of any covered benefits to the party who accepts assignment below.

**13.** Physician's or Authorizing Person's Signature: I authorize payment of the benefits to the undersigned physician or supplier for services described below.

**14.** Date of Current Illness

**15.** If Patient Has Had Same or Similar Illness

**16.** Date Patient Unable to Work in Current Occupation

**17.** Name of Referring Physician or Other Source

**18.** Hospitalization Dates Related to Current Services

**19.** Reserved for Local Use

**20.** Outside Lab?

**21.** Diagnosis or Nature of Illness or Injury

**22.** Medicaid Resubmission Code

**23.** Prior Authorization Number

**24.** Date of Service

**25.** Federal Tax I.D. Number

**26.** Patient's Account No.

**27.** Accept Assignment?

**28.** Total Charge

**29.** Amount Paid

**30.** Balance Due

**31.** Signature of Physician or Supplier

**32.** Name and Address of Facility Where Services Were Rendered

**33.** Physician's, Supplier's Billing Name, Address, Zip Code:

**APPROVED OMB-0506-0006 FORM CMS-15000 (12-90), FORM RR-15000, APPROVED OMB-1215-0006 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPSA)**

(/approved by ama council on medical service 8/88) please print or type

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