Physician Services

Anesthesia

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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 Anesthesia section of the Physician Services Handbook includes information for anesthesiologists and physician clinics regarding covered services, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers.

The Anesthesia section of the Physician Services Handbook includes information for anesthesiologists and physician clinics regarding covered services, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers.

Certified registered nurse anesthetists and anesthesiologist assistants should refer to the Anesthetist page of the Medicaid Web site for more information about covered services, reimbursement methodology, and billing.

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 providers with specific specialties.

Provider Numbers

Wisconsin Medicaid issues billing performing provider numbers and group billing provider numbers to anesthesiologists. Refer to the Medicine and Surgery section of this handbook for more information about provider numbers.

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.
- Routine follow-up visits.
- Transportation.
- Ultrasound services.

Anesthesia Services

Anesthesia services may include preoperative, intraoperative, and postoperative evaluation and management (E&M) of a recipient as appropriate.

Wisconsin Medicaid covers physician anesthesia services that are medically necessary to induce the loss of a recipient's sensation of pain associated with surgery or radiological services. Anesthesia services may include preoperative, intraoperative, and postoperative evaluation and management (E&M) of a recipient as appropriate.

Wisconsin Medicaid covers only those anesthesia services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective.

Procedure Codes and Modifiers

Medicaid-covered anesthesia services are identified by *Current Procedural Terminology* (CPT) procedure codes listed in Appendix 1 of this section. Anesthesia modifiers ("AA," "QY," or "QK") apply to most anesthesia services except for vascular injections, invasive monitoring, and catheter insertion. Refer to Appendix 1 of this section for modifiers allowable to anesthesia services.

Place of Service Codes

Providers are required to indicate two-digit place of service (POS) codes on claims and other forms, when applicable. Refer to Appendix 2 of this section for allowable POS codes and descriptions for anesthesia services.

Quantities — Time Versus Units

Anesthesia time begins when the anesthesiologist, certified registered nurse anesthetist (CRNA), or anesthesiologist assistant physically starts to prepare the recipient for the induction of anesthesia in the operating room and ends when the person performing the anesthesia service is no longer in constant attendance (when the recipient may be safely placed under postoperative supervision).

15-Minute Time Units

Except for Medicare crossover claims and CPT anesthesia procedure code 01953, claims for CPT codes 00100-01999 must be submitted using quantities of 15-minute time units. Providers should use the rounding guidelines in the following table.

Time (in minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
Etc.	

Anesthesia Services Using Other Quantities

A quantity of "1.0," not 15-minute time units, should be used when submitting claims for the following anesthesia services:

- Qualifying circumstances.
- Invasive monitoring.
- Postoperative and intractable pain management.
- Add-on procedure code 01953. (Time for 01953 is included in the quantity for the primary procedure.)

In addition, claims for vascular procedures should indicate the appropriate quantity (e.g., 2.0), not 15-minute time units.

Relative Value Units

Providers should *not* submit claims with relative value units (RVUs) for the procedure performed. Wisconsin Medicaid automatically includes RVUs when reimbursement is calculated.

Medicare Crossover Claims

For Medicare crossover claims only, providers should indicate the *actual number of minutes* performing anesthesia services, not 15-minute time units.

Claims with Quantities Greater Than 30 Units

A provider submitting a claim for anesthesia services with a quantity greater than 30 (more than 7½ hours) for the same date of service (DOS) is required to submit a paper CMS 1500 claim form along with appropriate supporting documentation (e.g., anesthesia report). Providers should write "MEDICAL CONSULTANT REVIEW REQUESTED" at the top of the claim in red ink.

Electronic claims indicating a quantity greater than 30 will be denied and must be resubmitted on a paper claim with the appropriate documentation attached.

Qualifying Circumstances

Anesthesia services are sometimes provided under difficult circumstances including:

- Extraordinary conditions of the patient.
- Special operative conditions.
- Unusual risk factors.

When these circumstances occur, the performing or supervising anesthesiologist may submit a claim with the appropriate qualifying circumstance procedure code(s) and modifier "AA" with a quantity of "1.0." A qualifying circumstance may be reimbursed in addition to the anesthesia procedure performed.

Invasive Monitoring

Wisconsin Medicaid covers invasive monitoring when performed by an anesthesiologist. Anesthesiologists are required to indicate a quantity of "1.0" when submitting claims for invasive monitoring.

Vascular Procedures

Vascular procedures may be reimbursable when performed in situations other than in the surgical suite. Wisconsin Medicaid does not reimburse anesthesiologists for qualifying circumstance procedure codes when the provider is also performing vascular procedures for the same recipient on the same DOS.

Anesthesiologists are required to indicate the number of services provided (e.g., "1.0") when submitting claims for vascular procedures.

Monitored Anesthesia Care

Providers should submit claims for monitored anesthesia care the same way they submit claims for standard anesthesia procedures.

Epidural Anesthesia

Wisconsin Medicaid separately reimburses for epidural anesthesia procedures only when performed as part of labor and delivery.

Obstetrical

For epidural anesthesia to be covered as part of labor and delivery, the anesthesiologist must be in constant attendance with the recipient. Time spent in constant attendance includes:

- Initiation of the epidural.
- Initial care.
- Intermittent face-to-face monitoring.
- Discontinuation of the epidural.

A qualifying circumstance may be reimbursed in addition to the anesthesia procedure performed.

Wisconsin Medicaid separately reimburses for CPT add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia.

Providers should submit claims for epidural anesthesia with the appropriate CPT anesthesia code along with the appropriate modifier in 15-minute time units. The recipient's medical record or anesthesia report must include the time actually spent in constant attendance with the recipient.

Refer to the following table for an example of how to submit a claim for epidural anesthesia for labor and delivery.

Example: Epidural Anesthesia for Labor (The claim is submitted with procedure code 01967 + modifier "AA" and appropriate 15-minute time units.)

Time (24-hour clock)	**Description**	**Time Units**
2230-2245	Epidural catheter inserted; prepare and drape; check blood pressure and pulse	1.0
0200-0215	Check previously inserted epidural catheter, blood pressure, and pulse	1.0
0415-0430	Check previously inserted epidural catheter, blood pressure, and pulse	1.0
0510-0530	Baby girl delivered at 0530; check blood pressure and pulse	2.0
0540-0555	Epidural catheter removed intact; sterile dressing applied to puncture site	1.0
	Billable Units	**6.0**

Wisconsin Medicaid does *not* reimburse for standby anesthesia services provided to recipients who have received an epidural during labor or delivery.

Postoperative and Intractable Pain Management

Wisconsin Medicaid covers epidural procedures provided for management of postoperative or intractable pain. Providers are required to indicate the appropriate CPT anesthesia code and a quantity of "1.0" when submitting claims for epidural procedures provided for the management of postoperative or intractable pain.

The appropriate E&M procedure code should be used when submitting claims for subsequent daily visits related to the epidural procedure. If more than one visit is required, submit an Adjustment/Reconsideration Request, HCF 13046, with appropriate documentation for the allowed claim. Providers should indicate "Medical Consultant Review Requested" on the form. Refer to the Medicaid Web site for a fillable Portable Document Format of the Adjustment/Reconsideration Request.

Add-On Codes

Wisconsin Medicaid separately reimburses for CPT add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia. Anesthesia add-on codes are reimbursed differently than other anesthesia codes. The add-on code must be submitted in addition to the primary anesthesia code. Wisconsin Medicaid reimburses for the following add-on codes:

- 01953 (Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area [TBSA] treated during anesthesia and surgery; each additional nine percent total body surface area or part thereof). Use 01953 in conjunction with code 01952.

  Billing note: All anesthesia time must be reported with primary anesthesia code 01952. Indicate a quantity of "1.0" for add-on code 01953.

- 01968 (Anesthesia for cesarean delivery following neuraxial labor analgesia/ anesthesia). Use 01968 in conjunction with code 01967.

  Billing note: Anesthesia time must be reported separately for primary code 01967 and add-on code 01968. Indicate quantities in 15-minute time units for each code.

- 01969 (Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia). Use 01969 in conjunction with code 01967.

  Billing note: Anesthesia time must be separately reported for primary code 01967 and add-on code 01969. Indicate quantities in 15-minute time units for each code.

As a reminder, do *not* submit claims with RVUs for the procedure performed. Wisconsin Medicaid automatically includes RVUs when reimbursement is calculated. Do not add RVUs and time units or indicate the actual time in minutes or hours.

Standby Anesthesiologist

Services performed by a standby anesthesiologist may be covered when the attending physician requests an anesthesiologist be immediately available on the premises. The standby anesthesiologist monitors the recipient's vital signs and observes the recipient, even though the surgery is actually being performed under local anesthesia. Wisconsin Medicaid reimburses the standby anesthesiologist as if general anesthesia had been administered. A standby anesthesiologist is covered only when medically necessary and documented in the recipient's medical record.

Standby anesthesia is not reimbursed when anesthesia, including an epidural, has already been administered.

When submitting claims for standby anesthesia, include the following:

- The anesthesia procedure code best describing the procedure performed.
- The number of 15-minute time units the anesthesiologist was face-to-face with the recipient or immediately available on the premises during a procedure.

Additional Anesthesiologist, Nurse Anesthetist, or Anesthesiologist Assistant

An additional anesthesiologist, CRNA, or anesthesiologist assistant may be required in certain surgical situations. Reimbursement for the additional provider is established by Wisconsin Medicaid.

Anesthesia by Surgeon

Typically, reimbursement for anesthesia provided by the surgeon (e.g., local infiltration, digital block, topical anesthesia, conscious sedation, and general anesthesia) is included in the reimbursement for the surgical or diagnostic procedure(s) performed and is not separately reimbursable.

However, if anesthesia is the primary procedure performed for diagnosis or treatment, it is separately reimbursable. For example, if an intercostal nerve block is performed for diagnosis and treatment of post-therapeutic neuralgia, and an epidural steroid injection procedure is also performed, the anesthesia procedure is separately reimbursable.

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Services performed by a standby anesthesiologist may be covered when the attending physician requests an anesthesiologist be immediately available on the premises.

Medical Direction

Medically directed anesthesia services are those services performed by a CRNA or an anesthesiologist assistant and directed by an anesthesiologist.

Wisconsin Medicaid reimburses anesthesiologists for *medical direction* of one, two, three, or four certified registered nurse anesthetists (CRNAs) or anesthesiologist assistants. This is only applicable during concurrent surgeries within a surgical suite. The concurrent surgeries do not have to involve Wisconsin Medicaid recipients.

Definition

Medically directed anesthesia services are those services performed by a CRNA or an anesthesiologist assistant and directed by an anesthesiologist. When a CRNA or anesthesiologist assistant is medically directed, the anesthesiologist is required to do *all* of the following (anything less is considered supervision):

1. Perform the pre-anesthesia examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable.
4. Monitor at frequent intervals the course of anesthesia administered.
5. Remain physically present on premises and available for immediate diagnosis and treatment of emergencies.
6. Provide indicated post-anesthesia care.

Wisconsin Medicaid does not cover general oversight of a surgical suite.

Medical Supervision (Non-Reimbursable)

Medically supervised anesthesia services are those services performed by a CRNA and supervised by the attending physician. Wisconsin Medicaid does not cover medical supervision of CRNAs.

Procedure Codes and Modifiers

Claims for medical direction should indicate the appropriate anesthesia *Current Procedural Terminology* procedure code with modifier "QY" (Medical direction of one CRNA by an anesthesiologist) or "QK" (Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals). Refer to Appendix 1 of this section for a list of anesthesia-related modifiers.

Wisconsin Medicaid does not cover the medical direction of five or more CRNAs or anesthesiologist assistants.

When qualifying circumstances for anesthesia exist, the supervising anesthesiologist may receive additional reimbursement by submitting a claim for a qualifying circumstance.

Note: Certified registered nurse assistants (CRNAs) and anesthesiologist assistants may not receive additional reimbursement for qualifying circumstances.

Billing Example for Special Situation

In this example, the number of CRNAs being medically directed changes during surgery: an anesthesiologist begins a three-hour surgery directing one CRNA. After one hour, a second surgery begins and the anesthesiologist directs a CRNA for that surgery as well. Two detail lines of the claim should be used when billing for this example. The first detail line should indicate the appropriate anesthesia procedure code, modifier "QY," and a quantity of 4.0.

The second detail line should include the same procedure code as on the first line, but modifier

"QK" should be used to represent the second CRNA. Because the doctor directed the two CRNAs for two hours, the quantity is 8.0.

Claims Submission and Reimbursement

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors.

This chapter includes claims submission and reimbursement information for anesthesiologists. 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, 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 anesthesia services that must be submitted on the CMS 1500 paper claim include anesthesia services with a quantity greater than 30.

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

Refer to Appendix 3 of this section for CMS 1500 claim form completion instructions. Refer to Appendices 4 and 5 of this section for sample completed CMS 1500 claim forms for anesthesia 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 CMS 1500 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.

Reimbursement

Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for a reimbursable procedure code.

Wisconsin Medicaid sets the maximum allowable fee for each anesthesia service 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

General Anesthesia and Medical Direction

Wisconsin Medicaid's usual reimbursement for general anesthesia and medical direction is equal to the lesser of the billed amount or the relative value units (RVUs) for the major procedure plus the number of 15-minute time units, multiplied by the maximum allowable fee for the procedure. Wisconsin Medicaid automatically assigns RVUs, established by the American Society of Anesthesiologists, for covered anesthesia services.

For example, if the RVU for the anesthesia procedure provided is 4.00, the maximum allowable fee is $17.57, and the surgery lasted an hour and a half (which translates to a billed quantity of 6.0), the Medicaid reimbursement would be calculated as follows:

$$(4+6) \times 17.57 = \$175.70$$

The RVU and the maximum allowable fee assigned to each procedure code is indicated in the physician services maximum allowable fee schedule.

Since the RVU includes usual pre- and postoperative visits, the administration of the anesthetic, and incidental administration of fluids and/or blood, Wisconsin Medicaid will not separately reimburse providers for these services in addition to the reimbursement for anesthesia. Anesthesiologists are not separately reimbursed for drugs administered during anesthesia.

Qualifying Circumstances

The reimbursement formula for qualifying circumstances is the same as the formula for general anesthesia, except that the quantity for qualifying circumstances is always "1.0." Reimbursement for qualifying circumstances is equal to the lesser of the billed amount or the maximum allowable fee for the procedure.

Invasive Monitoring

Reimbursement for invasive monitoring is equal to the lesser of the billed amount or the maximum allowable fee for the procedure. The quantity for invasive monitoring is always "1.0."

Vascular Procedures

Vascular procedures are reimbursed only when performed outside the surgical suite at the

Wisconsin Medicaid's usual reimbursement for general anesthesia and medical direction is equal to the lesser of the billed amount or the relative value units (RVUs) for the major procedure plus the number of 15-minute time units, multiplied by the maximum allowable fee for the procedure.

lesser of the billed amount or the quantity multiplied by the maximum allowable fee for the procedure.

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 7½ 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.

Total reimbursement for anesthesia services claims typically should not reach Wisconsin Medicaid's maximum daily reimbursement.

Total reimbursement for anesthesia services claims typically should not reach Wisconsin Medicaid's maximum daily reimbursement. Any claim reaching this maximum daily reimbursement level is subject to post-pay review and audit.

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 anesthesia services. 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 Anesthesia Services

The following table includes allowable *Current Procedural Terminology* (CPT) procedure codes and modifiers for physician anesthesia services. These codes are updated on 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.

Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
QY	Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

Service	CPT Procedure Codes	Modifier Required?
Head	00100-00222	Yes
Neck	00300-00352	Yes
Thorax (Chest Wall and Shoulder Girdle)	00400-00474	Yes
Intrathoracic	00500-00580	Yes
Spine and Spinal Cord	00600-00670	Yes
Upper Abdomen	00700-00797	Yes
Lower Abdomen	00800-00882	Yes
Perineum	00902-00952	Yes
Pelvis (Except Hip)	01112-01190	Yes
Upper Leg (Except Knee)	01200-01274	Yes
Knee and Popliteal Area	01320-01444	Yes
Lower Leg (Below Knee, Includes Ankle and Foot)	01462-01522	Yes
Shoulder and Axilla	01610-01682	Yes
Upper Arm and Elbow	01710-01782	Yes
Forearm, Wrist, and Hand	01810-01860	Yes
Radiological Procedures	01905-01933	Yes
Burn Excisions or Debridement	01951-01953	Yes
Obstetric	01958-01969	Yes
Other Procedures	01990-01999	Yes
Vascular Injection Procedures (When Anesthesia Is Not Provided)	36000-36248, 36568-36569, 36580, 36584, 36600-36660	No*
Invasive Monitoring	36555-36556, 36620, 93503	No*
Catheter/Injections/Nerve Blocks	62256, 62280-62281, 62310-62319, 64400-64530	No*
Qualifying Circumstances for Anesthesia	99100-99140	Yes (AA only)

*Use of modifiers for these procedure codes will result in denied claims.

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Appendix 2

Allowable Place of Service Codes for Physician Anesthesia 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 providers are required to use when submitting claims for physician anesthesia 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
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
71	Public Health Clinic
72	Rural Health Clinic

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Appendix 3

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 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 3
(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)

Appendix 3
(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 anesthesia 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 3
(Continued)

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Appendix 2 of this section for allowable POS codes for physician 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 Appendix 1 of this section for allowable modifiers for physician anesthesia services.

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 submit claims to Wisconsin Medicaid with 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

Current Procedural Terminology (CPT) procedure codes 00100-01999, except for 01953, must be billed in quantities of 15-minute increments. (Time for 01953 is included in the quantity for the primary procedure; 01953 is billed with a quantity of 1.0.) Do *not* indicate the relative value units of the anesthesia procedure performed. A quantity of "1.0" should be used when submitting claims for the following anesthesia services:

- Qualifying circumstances.
- Invasive monitoring.
- Postoperative and intractable pain management.
- Add-on procedure code 01953.

For vascular procedures, a quantity greater than "1.0" may be indicated.

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 Medicaid remittance information.

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 4

Sample CMS 1500 Claim Form for Physician Anesthesia Services
(Medical Direction of a Single Anesthetist with Qualifying Circumstances)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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; Employed | Full-Time Student | Part-Time Student

CITY | STATE

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

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. 575.10
2. 284.8
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	11 06 04	21		00790	QY	1	XXX XX	8.0				12345678
2	11 06 04	21		99135	AA	2	XX XX	1.0				12345678
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: $ XXX 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. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# 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)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 5

Sample CMS 1500 Claim Form for Physician Anesthesia Services
(Medical Direction of Two, Three, or Four Concurrent Procedures)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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. 575.10 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 11 03 04		21		00790	QK	1	XXX XX	4.0				12345678
2 11 03 04		21		99135	AA	1	XX XX	8.0				12345678
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 $ XXX 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. Billing
1 W. Williams
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PIN# GRP#

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APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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