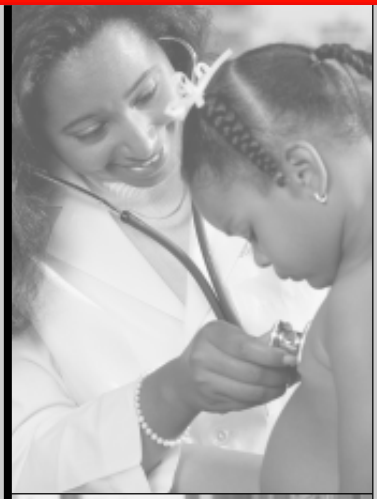
All Provider



Claims Information

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)

Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

Certification and Ongoing Responsibilities
• Certification and recertification. • Change of address or status. • Documentation requirements. • Noncertified providers. • Ongoing responsibilities. • Provider rights. • Provider sanctions. • Recipient discrimination prohibited. • Release of billing information.

Claims Information
• Follow-up procedures. • Good Faith claims. • Preparing and submitting claims. • Reimbursement information. • Remittance information. • Submission deadline. • Timely filing appeals requests.

Coordination of Benefits
• Commercial health insurance. • Crossover claims. • Medicare. • Other Coverage Discrepancy Report, HCF 1159. • Primary and secondary payers. • Provider-based billing.

Covered and Noncovered Services
• Collecting payment from recipients. • Covered services. • Emergency services. • HealthCheck "Other Services." • Medical necessity. • Noncovered services.

Informational Resources
• Electronic transactions. • Eligibility Verification System. • Maximum allowable fee schedules. • Forms. • Medicaid Web site. • Professional relations representatives. • Provider Services. • Publications.

Managed Care
• Covered and noncovered HMO and SSI MCO services. • Enrollee HMO and SSI MCO eligibility. • Enrollment process. • Extraordinary claims. • HMO and SSI MCO claims submission. • Network and non-network provider information. • Provider appeals.

Prior Authorization
• Amending prior authorization (PA) requests. • Appealing PA decisions. • Grant and expiration dates. • Prior authorization for emergency services. • Recipient loss of eligibility during treatment. • Renewal requests. • Review process. • Submitting PA requests.

Recipient Eligibility
• Copayment requirements. • Eligibility categories. • Eligibility responsibilities. • Eligibility verification. • Identification cards. • Limited benefit categories. • Misuse and abuse of benefits. • Retroactive eligibility.

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Preface

This All-Provider Handbook is issued to all Medicaid-certified 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 this handbook for information about state-contracted managed care organizations.

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 provider is responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by the provider or by an outside billing service or clearinghouse.

Providers may submit claims only *after* the service, item, or supply is provided.

A provider may not seek reimbursement from Wisconsin Medicaid for a noncovered service by charging Wisconsin Medicaid for a covered service that was not actually provided to the recipient and then applying Medicaid reimbursement toward the noncovered service. In addition, a provider may not seek reimbursement for two separate covered services to receive additional reimbursement over the maximum allowed amount for the one service that was provided. Such actions are considered fraudulent.

According to HFS 106.03(5)(c)2, Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from Wisconsin Medicaid. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Wisconsin Medicaid will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferral of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims to Wisconsin Medicaid. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

Providers may not discriminate against Medicaid recipients by charging Wisconsin Medicaid a higher fee for the same service than that charged to a private-pay patient.

For services requiring a recipient copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the recipient should not be deducted from the charge submitted to Wisconsin Medicaid. When applicable, Wisconsin Medicaid automatically deducts the copayment amount.

For most services, Wisconsin Medicaid reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established by Wisconsin Medicaid. Refer to service-specific publications for more information about Medicaid reimbursement.

Acceptance of Payment

The amounts allowed by Wisconsin Medicaid as payment for Medicaid-covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any Medicaid copayment or spenddown amounts paid by the recipient, and any amount paid by Wisconsin Medicaid) may not exceed the Medicaid-allowed amount. As a result, providers may not collect payment from a recipient, or authorized person acting on behalf of the recipient, for the difference between their usual and customary charge and the Medicaid-allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the Medicaid-allowed amount if no additional payment is received from the recipient or Wisconsin Medicaid.

Maximum Allowable Fees

Wisconsin Medicaid establishes maximum allowable fees for most covered services. 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 Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

A maximum allowable fee schedule lists all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code. Refer to the Informational Resources section of this handbook for information about obtaining fee schedules.

The amounts allowed by Wisconsin Medicaid as payment for Medicaid-covered services must be accepted as payment in full.

Submission Deadline

Wisconsin Medicaid recommends that providers submit Medicaid claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

Except as noted under "Exceptions to the Submission Deadline" in this chapter, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims with Wisconsin Medicaid.

Providers are responsible for resolving claims with Wisconsin Medicaid. Recipients are not responsible for resolving claims with Wisconsin Medicaid. To resolve claims before the submission deadline, Wisconsin Medicaid encourages providers to use all available resources. Providers should refer to the Informational Resources section of this handbook for detailed information about these resources.

Medicaid Claims

To receive reimbursement, claims and adjustment requests must be received by Wisconsin Medicaid within 365 days of the date of service (DOS). This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

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. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Exceptions to the Submission Deadline

State and federal laws provide eight exceptions to the submission deadline. According to federal regulations and HFS 106.03, Wis. Admin. Code, Wisconsin Medicaid may consider exceptions to the submission deadline only in the following circumstances:

- Change in a nursing home resident's level of care or liability amount.
- Decision made by a court order, fair hearing, or the Department of Health and Family Services.
- Denial due to discrepancy between the recipient's eligibility file and the recipient's actual eligibility.
- Medicaid reconsideration or recoupment.
- Medicaid retroactive eligibility for persons on General Relief.
- Medicare denial occurs after Wisconsin Medicaid's submission deadline.
- Refund request from an other health insurance source.
- Retroactive recipient eligibility.

Wisconsin Medicaid has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing. Refer to the Timely Filing Appeals Requests chapter of this section and Appendix 1 of this section for information about submitting timely filing appeals requests.

Claims Submission

Providers should submit all services relating to a date of service or month of service on a single claim.

Transactions and Forms

Wisconsin Medicaid requires providers to use specific claim transactions or claim forms. Providers should refer to service-specific publications for information about which claim transaction or claim form to submit.

Providers are encouraged to submit claims electronically.

Submission Options

Providers may submit claims to Wisconsin Medicaid electronically or on paper. Providers are encouraged to submit claims electronically. Electronic claims submission:

- Adapts to existing systems.
- Allows flexible submission methods.
- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Providers are required to submit a paper claim, not an electronic claim, when submitting a claim that requires additional documentation.

Electronic Claims

Providers should refer to service-specific publications for information about submitting claims using an 837 Health Care Claim (837) transaction or the National Council for Prescription Drug Programs 5.1 Telecommunication Standard for Retail Pharmacy Claims transaction.

All providers should refer to the Informational Resources section of this handbook for general information about submitting electronic transactions.

Provider Electronic Solutions Software

The Division of Health Care Financing (DHCF) offers electronic billing software at no cost to the provider. The Provider Electronic Solutions (PES) software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may request it through the Medicaid Web site. Providers may also obtain the software by contacting the DHCF Electronic Data Interchange Helpdesk by telephone at (608) 221-9036 or by e-mail at *wiedi@dhfs.state.wi.us*.

Paper Claims

Providers should refer to service-specific publications for information about specific paper claim forms and their availability.

To promote accurate and timely processing of paper claims, providers should follow these suggestions:

- Follow the claim form instructions found in service-specific publications.
- Supply all data in a legible manner on the claim form.

Providers may submit photocopied claims if the claims are legible. Submit completed paper claims to the following address:

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

Providers may not attach documentation to a claim unless specifically requested by Wisconsin Medicaid, as in the following examples:

- A copy of Medicaid remittance information is attached to a good faith claim.
- A copy of Medicare remittance information is attached to a crossover claim.
- A Sterilization Informed Consent form, HCF 1164, is attached to a sterilization surgery claim.
- An Acknowledgment of Receipt of Hysterectomy Information form, HCF 1160, is attached to a hysterectomy surgery claim.
- Documentation is attached to a Timely Filing Appeals Request form, HCF 13047.

Copayment Amounts

Copayment amounts collected from recipients should not be deducted from the charges submitted to Wisconsin Medicaid. Providers should indicate their usual and customary charges for all services provided.

In addition, copayment amounts should not be included when indicating the amount paid by other health insurance sources.

Wisconsin Medicaid automatically deducts the appropriate copayment amount from payments allowed by Wisconsin Medicaid. Medicaid remittance information reflects the automatic deduction of applicable copayment amounts.

Refer to the Recipient Eligibility section of this handbook for more information about collecting copayment amounts.

State-Contracted Managed Care Organizations

Claims for services that are covered in a recipient's state-contracted managed care organization (MCO) should be submitted to that MCO. Refer to the Managed Care section of this handbook for information about program requirements for submitting claims to state-contracted MCOs.

Extraordinary Claims

Extraordinary claims are Medicaid claims that have been denied by a Medicaid HMO or SSI MCO and should be submitted to Wisconsin Medicaid. Refer to the Managed Care section of this handbook for information about submitting extraordinary claims.

Noncertified Providers

Noncertified providers should refer to the Certification and Ongoing Responsibilities section of this handbook for more information about submitting claims to Wisconsin Medicaid.

Copayment amounts collected from recipients should not be deducted from the charges submitted to Wisconsin Medicaid.

Responses to Claims Submission

Although this chapter is designed to provide general information about responses to claims submission, the response process varies for pharmacy providers. Pharmacy providers should refer to service-specific publications for information about responses to claims submitted using the National Council for Prescription Drug Programs (NCPDP) 5.1 Telecommunication Standard for Retail Pharmacy Claims transaction.

The claim number consists of 15 digits that identify valuable information (e.g., the date the claim was received by Wisconsin Medicaid, how the claim was submitted) about the claim or adjustment request.

Claim Number

Each claim or adjustment request received by Wisconsin Medicaid is assigned a unique claim number (also known as the internal control number or ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned a claim number.

The claim number consists of 15 digits that identify valuable information (e.g., the date the claim was received by Wisconsin Medicaid, how the claim was submitted) about the claim or adjustment request. Refer to Appendix 2 of this section for information about interpreting claim numbers.

Remittance Information

Medicaid remittance information, which is available electronically and on paper, provides useful information regarding the processing of claims and adjustment requests.

Electronic Remittance Information

Electronic remittance information may be obtained using the 835 Health Care Claim Payment/Advice (835) transaction. It provides the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, denied claims submitted using the NCPDP 5.1 transaction will not appear on Medicaid remittance information.

Refer to the Informational Resources section of this handbook for more information about receiving the 835 transaction.

Provider Electronic Solutions Software

The Division of Health Care Financing (DHCF) offers electronic billing software at no cost to the provider. The Provider Electronic Solutions (PES) software allows providers to download the 835 transaction. To obtain PES software, providers may request the software through the Medicaid Web site. Providers may also obtain the software by contacting the DHCF Electronic Data Interchange Helpdesk by telephone at (608) 221-9036 or by e-mail at *wiedi@dhfs.state.wi.us*.

Paper Remittance and Status Report

Wisconsin Medicaid sends a paper Remittance and Status (R/S) Report once a week to all providers who had at least one claim or adjustment request finalized that week. Each R/S Report includes the following:

- Remittance information for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, denied claims submitted using the NCPDP 5.1 transaction will not appear on Medicaid remittance information.
- A numeric Explanation of Benefits (EOB) code that is specific to Wisconsin Medicaid and corresponds to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail. A list of the EOB codes used, with their description, appears on the last page of each R/S Report.

- A banner page with R/S Report messages that provide important, time-sensitive information for providers. Refer to the Informational Resources section of this handbook for more information about obtaining R/S Report messages.

Refer to the following appendices for more information about reading R/S Reports:

- Refer to Appendix 3 of this section for a sample R/S Report.
- Refer to Appendix 4 of this section for instructions about reading the R/S Report.
- Refer to Appendix 5 of this section for instructions about reading adjustments on the R/S Report.

Obtaining Copies

Wisconsin Medicaid provides initial R/S Reports at no cost to providers. Additional copies are available for a fee. Providers may request additional copies of R/S Reports by calling Provider Services at (800) 947-9627 or (608) 221-9883 or by sending a written request to the following address:

Wisconsin Medicaid
Written Correspondence
6406 Bridge Rd
Madison WI 53784-0005

When sending written requests, providers should include the following:

- Provider name.
- Provider number.
- Date(s) of the R/S Report(s) being requested.

Verifying Accuracy of Claims Processing

After obtaining Medicaid remittance information, providers should compare it to the claims or adjustment requests to verify that Wisconsin Medicaid processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a recipient's account, providers should note the date on the Medicaid remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

When posting a payment or denial to a recipient's account, providers should note the date on the Medicaid remittance information that indicates the claim or adjustment has finalized.

Split Claims May Appear Separately

Electronic claims that are split into multiple claims by Wisconsin Medicaid will be reported as multiple claims on Medicaid remittance information. As a result, multiple claims resulting from a split claim may not appear on the same 835 transaction or R/S Report.

The following electronic claims may be split:

- Claims with more than 28 detail lines.
- Dental claims with multiple tooth numbers per detail.
- Claims with the same service for consecutive dates of service (i.e., span dates). (This is not true for rental services or services provided by nursing home providers.)

Verifying the Check Amount on Remittance and Status Reports

To properly balance recipient accounts, it is important to understand how to read and verify R/S Reports. Follow these steps when verifying the amount of the check sent with an R/S Report:

To properly balance recipient accounts, it is important to understand how to read and verify R/S Reports.

- When verifying an R/S Report without recoupments, add all claim type subtotals. This total equals the total paid (amount of the check) on the R/S Report.
- When verifying an R/S Report with recoupments, the following steps should be taken:
  - ✓ *Add* all claim type subtotals.
  - ✓ *Add* all EOB "601" ("receivable established for balance of $XX.XX which will be withheld from future payment") deductions into the subtotal.
  - ✓ *Subtract* all EOB "331" ("payment reduced due to an adjustment of the following claim - ICN: XXXXXXXXXXXXXXX") amounts, which are found at the end of the report, from the paid claims total.

  The result of this formula equals the total paid on the R/S Report.

Claim Status

Wisconsin Medicaid generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a claim or adjustment request using the Automated Voice Response (AVR) system or the 276/277 Health Care Claim Status Request and Response (276/277) transaction. Providers should refer to the Informational Resources section of this handbook for more information about the AVR system, the 276/277 transaction, and other claim status inquiry methods.

If a claim or adjustment request does not appear in claim status within 45 days of the date of submission, a copy of the original claim or adjustment request should be resubmitted through normal processing channels.

Adjustment Requests

After reviewing both the claim and Medicaid remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate payments (overpayments and underpayments).
- To add and delete services.
- To supply additional information that may affect the amount of reimbursement.
- To request professional consultant review (e.g., medical, dental).

To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to Wisconsin Medicaid. An allowed claim (or adjustment request) contains at least one service that is reimbursable. It displays a dollar amount *greater* than "0" in the amount field of Medicaid remittance information even though a payment may not have been made. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Within 30 days of receipt, Wisconsin Medicaid generally reprocesses the original claim with the changes indicated on the adjustment request and responds on Medicaid remittance information.

Electronic Adjustment Requests

Even if the original claim was submitted on paper, providers may submit electronic adjustment requests using an 837 Health Care Claim (837) transaction. However, providers are required to submit a paper adjustment request, not an electronic adjustment request, when submitting an adjustment request that requires additional documentation.

Claims submitted using the National Council for Prescription Drug Programs (NCPDP) 5.1 Telecommunication Standard for Retail Pharmacy Claims transaction can not be adjusted using an 837 transaction. Pharmacy providers should refer to service-specific publications for more information about the NCPDP 5.1 transaction.

All providers should refer to the Informational Resources section of this handbook for general information about electronic transactions.

Provider Electronic Solutions Software

The Division of Health Care Financing (DHCF) offers electronic billing software at no cost to providers. The Provider Electronic Solutions (PES) software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may request it from the Medicaid Web site. Providers may also obtain the software by contacting the DHCF Electronic Data Interchange (EDI) Helpdesk by telephone at (608) 221-9036 or by e-mail at *wiedi@dhfs.state.wi.us*.

Paper Adjustment Requests

The completion instructions and Adjustment/ Reconsideration Request form, HCF 13046, from are located in Appendices 6 and 7 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Follow-Up to Adjustment Requests

Providers who believe an error has occurred or their issues have not been satisfactorily resolved may:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI Helpdesk for assistance with electronic adjustment requests.

Good Faith Claims

A good faith claim may be submitted when a claim is denied by Wisconsin Medicaid due to a discrepancy between the recipient's eligibility file and the recipient's actual eligibility.

A good faith claim may be submitted when a claim is denied by Wisconsin Medicaid due to a discrepancy between the recipient's eligibility file and the recipient's actual eligibility. Good faith claims must be submitted on paper because a national standard for electronic claim attachments has not been established at this time.

When both of the following circumstances occur, a claim may be denied by Wisconsin Medicaid:

- The recipient presents a beige paper Presumptive Eligibility (PE) for Pregnant Women Benefit identification card, green paper temporary identification card, or white paper PE for the Family Planning Waiver Program (FPWP) identification card.
- The provider submits the claim prior to Wisconsin Medicaid receiving the recipient's eligibility information.

In this situation, a claim may be denied with an eligibility-related Explanation of Benefits (EOB) code, and a good faith claim may then be submitted. Submitting good faith claims to Wisconsin Medicaid eliminates the need for the provider to contact the recipient's certifying agency.

A claim that is denied based on an EOB code listed in Appendix 8 of this section may be submitted to Good Faith if the dates of service (DOS) are *within* the claim submission deadline.

Before submitting a good faith claim, the provider is encouraged to verify through the Medicaid Eligibility Verification System (EVS) that Wisconsin Medicaid has not received the recipient's correct eligibility information. If the recipient's eligibility information has been updated, the provider should not submit a good faith claim. Instead, the provider should submit one of the following to Wisconsin Medicaid:

- An adjustment request if the original claim is in an allowed status.
- A new claim if the original claim is in a denied status.

To receive Medicaid consideration for a good faith claim, providers are required to submit the following:

- A legible copy of the claim.
- A copy of Medicaid remittance information showing a qualifying eligibility-related denial.
- A photocopy of one of the following indicating eligibility on the DOS:
  - ✓ Beige paper PE for Pregnant Women Benefit identification card.
  - ✓ Green paper temporary identification card.
  - ✓ White paper PE for the FPWP identification card.
  - ✓ The response received through the EVS from a commercial eligibility verification vendor.
  - ✓ The transaction log number received through the Automated Voice Response system.

Pharmacy providers should refer to service-specific publications for more information about submitting good faith claims.

Wisconsin Medicaid will do the following when a good faith claim is received:

- Enter the claim into the claims processing system.
- Suspend the claim.
- Make an inquiry to the certifying agency in an effort to update the recipient's eligibility file (this includes waiting for a response for a period of up to 70 days).
- Update the recipient's file.
- Release the claim to complete processing when the recipient's file is updated.

Submit good faith claims to the following address:

Wisconsin Medicaid
Good Faith
PO Box 6215
Madison WI 53784-6215

A good faith claim that contains DOS *beyond* the claim submission deadline must be submitted to Good Faith/Timely Filing. Refer to the Timely Filing Appeals Requests chapter of this section and Appendix 1 of this section for more information about submitting these claims.

A good faith claim that contains DOS *beyond* the claim submission deadline must be submitted to Good Faith/Timely Filing.

Timely Filing Appeals Requests

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider may submit a timely filing appeals request. Timely filing appeals requests must be submitted on paper because a national standard for electronic claim attachments has not been established at this time.

Dates of service (DOS) that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received by Wisconsin Medicaid that contain both current and late DOS are processed through normal channels without review by Timely Filing. Late DOS will be denied.

To receive Medicaid consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request form, HCF 13047.
- A legible claim or adjustment request.
- All required documentation as noted in Appendix 1 of this section.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, place of service code, etc., as effective for the DOS. However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for timely filing appeals requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, place of service code, etc., as effective for the DOS.

To receive consideration, timely filing appeals requests must be received before the deadlines specified in Appendix 1 of this section.

Decisions on timely filing appeals requests cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested by Wisconsin Medicaid.
- Wisconsin Medicaid receives the documentation before the specified deadline for the exception.

The Timely Filing Appeals Request form is located in Appendix 9 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Overpayments

As stated in HFS 106.04(5), Wis. Admin. Code, the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from Wisconsin Medicaid or other health insurance sources.

As stated in HFS 106.04(5), Wis. Admin. Code, the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from Wisconsin Medicaid or other health insurance sources.

In the case of all other Medicaid overpayments (e.g., incorrect claims processing, incorrect maximum allowable fee paid), providers are required to return the overpayment within 30 days of the date of discovery.

The return of overpayments may occur through one of the following methods:

- Return of overpayment through the adjustment request process.
- Return of overpayment with a cash refund (except nursing home providers and hospital providers).
- Medicaid-initiated adjustments.

Return of Overpayments Through Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels. Providers should refer to the Coordination of Benefits section of this handbook for information about provider-based billing.

Wisconsin Medicaid processes an adjustment request if the provider is all of the following:

- Medicaid certified on the date of service (DOS).
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under HFS 106.08, Wis. Admin. Code.
- Claiming and receiving Medicaid reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

Wisconsin Medicaid will deduct the overpayment when the electronic adjustment request is processed.

Refer to the appropriate companion document for detailed information about electronic adjustment requests. Refer to the Informational Resources section of this handbook for information about submitting electronic transactions.

Paper Adjustment Requests

For paper adjustment requests, providers are required to:

- Submit an Adjustment/Reconsideration Request form, HCF 13046, through normal processing channels (not Timely Filing), regardless of the DOS.
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim.

After the paper adjustment request is processed, Wisconsin Medicaid will deduct the overpayment from future reimbursement amounts.

Refer to the Adjustment Requests chapter of this section for more information about submitting adjustment requests.

Return of Overpayments with Cash Refunds

With the exception of nursing home and hospital providers, providers may return an overpayment to Wisconsin Medicaid with a cash refund. (Nursing home and hospital providers routinely receive retroactive rate adjustments, requiring Wisconsin Medicaid to reprocess previously paid claims to reflect a new rate. This is not possible after a cash refund is done.)

When correcting an overpayment with a cash refund, the cash refund must be submitted on paper because Wisconsin Medicaid does not accept electronic funds transfers.

The completion instructions and Claim Refund form, HCF 13066, are located in Appendices 10 and 11 of this section and may also be downloaded and printed from the Medicaid Web site.

The Claim Refund form should be submitted to Wisconsin Medicaid with either the Medicaid-issued check or provider-issued refund check.

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to Wisconsin Medicaid in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since the following information is true:

- A cash refund does not provide documentation for provider records as an adjustment request does (providers may be required to submit proof of the refund at a later time).
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

With the exception of nursing home and hospital providers, providers may return an overpayment to Wisconsin Medicaid with a cash refund.

Medicaid-Initiated Adjustments

Wisconsin Medicaid may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. Wisconsin Medicaid has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If Wisconsin Medicaid initiates an adjustment to recover overpayments, Medicaid remittance information will indicate the following:

- The dollar amount of the recoupment.
- The claim or claims that are subject to recoupment.
- A region of "80" in the claim number indicating that Wisconsin Medicaid initiated the adjustment (Refer to Appendix 2 of this section for information about interpreting claim numbers).

Appendix

Appendix 1

Allowable Exceptions to the Submission Deadline

The following table lists the eight allowable exceptions to the claim submission deadline. It also provides the filing deadlines and documentation requirements for each exception. In addition to the documentation listed below, providers are required to submit a Timely Filing Appeals Request form, HCF 13047, and a paper claim or an Adjustment/Reconsideration Request form, HCF 13046, for each exception.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a nursing home claim is initially received by Wisconsin Medicaid within the submission deadline and reimbursed incorrectly due to a change in the recipient's authorized level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the date of service (DOS) and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request form. The most recent claim number (also known as the internal control number or ICN) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a Medicaid-initiated adjustment.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Decision Made by a Court, Fair Hearing, or the Department of Health and Family Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the Department of Health and Family Services (DHFS).	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. A complete copy of the notice received from the court, fair hearing, or DHFS must be submitted with the request.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Appendix 1
(Continued)

Denial Due to Discrepancy Between the Recipient's Eligibility File and the Recipient's Actual Eligibility		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by Wisconsin Medicaid within the submission deadline but is denied due to a discrepancy between the recipient's eligibility file and the recipient's actual eligibility.	To receive consideration, the following documentation must be submitted within 455 days from the DOS: • A copy of Medicaid remittance information showing the claim was submitted in a timely manner and denied with a qualifying eligibility-related explanation. • A photocopy of one of the following indicating eligibility on the DOS: ✓ Beige paper Presumptive Eligibility (PE) for Pregnant Women Benefit identification card. ✓ Green paper temporary identification card. ✓ White paper PE for the Family Planning Waiver Program identification card. ✓ The response received through the Medicaid Eligibility Verification System from a commercial eligibility verification vendor. ✓ The transaction log number received through the Automated Voice Response system. Pharmacy providers should refer to service-specific publications for more information.	Wisconsin Medicaid Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Medicaid Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when Wisconsin Medicaid reconsiders a previously processed claim. Wisconsin Medicaid will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the Remittance and Status (R/S) Report message. A copy of the R/S Report message that shows the Medicaid-initiated adjustment must be submitted with the request.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Medicaid Retroactive Eligibility for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the local county/tribal social or human services agency requests a return of a general relief payment from the provider because a recipient has become retroactively eligible for Wisconsin Medicaid.	To receive consideration, the request must be submitted within 180 days from the date the backdated eligibility was added to the recipient's eligibility file. The request must be submitted with one of the following: • "GR retroactive eligibility" indicated on the claim. • A copy of the letter received from the county/tribal social or human services agency.	Wisconsin Medicaid GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050

Appendix 1
(Continued)

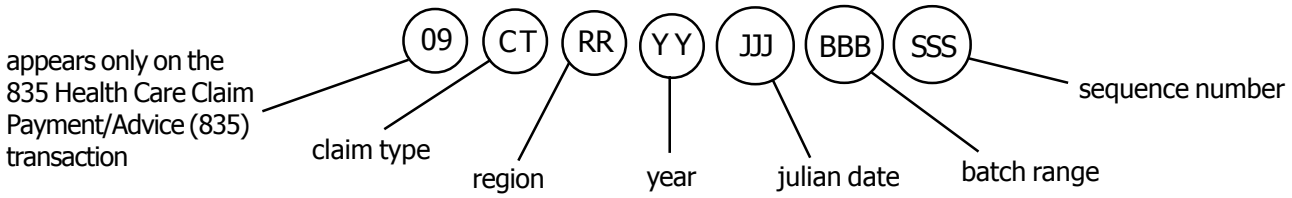
Medicare Denial Occurs After Wisconsin Medicaid's Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the Medicaid 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The recipient name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Refund Request from Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information. • A copy of the Medicaid remittance information showing recoupment for crossover claims when Medicare is recouping payment.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Recipient Eligibility		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a recipient's retroactive eligibility.	To receive consideration, the request must be submitted within 180 days from the date the backdated eligibility was added to the recipient's eligibility file. In addition, "retroactive eligibility" must be indicated on the claim.	Wisconsin Medicaid Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Appendix 2
Interpreting Claim Numbers

Each claim and adjustment by Wisconsin Medicaid is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
09 — When reported on the 835 transaction, claim numbers begin with 09.	Not applicable.
Claim type — Two digits indicate the claim type.	10 — Drug claim 19 — Drug adjustment 20 — Professional claim (e.g., physicians, chiropractors, nurse practitioners) 21 — Dental claim 23 — Outpatient hospital claim 24 — Miscellaneous claim (e.g., transportation, physical therapy, home health) 30 — Professional crossover claim, drug crossover claim, or miscellaneous crossover claim 31 — Outpatient hospital crossover claim 39 — Professional adjustment, dental adjustment, miscellaneous adjustment, or outpatient hospital adjustment 40 — Inpatient hospital claim 41 — Nursing home claim 49 — Inpatient hospital adjustment 50 — Inpatient hospital crossover 51 — Nursing home crossover claim 59 — Nursing home adjustment
Region — Two digits indicate the region. The region indicates how Wisconsin Medicaid received the claim or adjustment request.	10 — Retroactive rate adjustment 11 — Electronic claim or adjustment submitted using an 837 Health Care Claim transaction 12 — Automatic crossover claim, automatic crossover adjustment, electronic provider-submitted crossover claim, or electronic provider-submitted adjustment 80 — Medicaid-initiated adjustment 84 — Provider-based billing adjustment 85 — Pharmacy claim submitted using Point-of-Sale (POS) 86 — Pharmacy claim submitted using POS 87 — Pharmacy claim submitted using POS 98 — Paper claim, paper adjustment, paper provider-submitted crossover claim, or pharmacy adjustment submitted using POS
Year — Two digits indicate the year Wisconsin Medicaid received the claim or adjustment request.	For example, the year 2005 would appear as 05.
Julian date — Three digits indicate the day of the year, by Julian date, that Wisconsin Medicaid received the claim or adjustment request.	For example, February 2 would appear as 033.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by Wisconsin Medicaid.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by Wisconsin Medicaid.

Appendix 3

Sample Remittance and Status Report

REMITTANCE AND STATUS REPORT

WISCONSIN MEDICAID AND BADGERCARE PROGRAMS
6406 Bridge Road | Voice Response 800/947-3544 608/221-4247
Madison, WI 53784 | Policy/Billing 800/947-9627 608/221-9883

I.M. BILLING
ONE WEST WILLIAMS
ANYTOWN, WI 55555

R/S NUMBER 1 2 3 4 5 6 7 8 9

PROVIDER NUMBER 12345678 **REPORT SEQ NUMBER** 3 **DATE** MM/DD/YY **PAGE** 2

PATIENT NAME/ID NUMBER SERVICE DATES FROM | TO	U D	N S	PERF PROV/ RX NUMBER	MEDICAL RECORD NO DAYS QTY	PROC/ACCOM/ DRUG CDE/M1 M2 M3 M4	PATIENT CONTROL NO PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	CLAIM NUMBER TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
PAID OR DENIED CLAIMS												
RECIPIENT IM			/ 1234567890	1234 JED		124	209805033XXXXXX					
110603 110603			81234567	100	99202 TJ	OFFICE / OP VISIT - NEW PATIEN	XXXX	XXXX	XXX	XXX	XXXX	12
110703 110703			81234567	100	99214 TJ	OFFICE / OP VISIT - ESTABLISHE PATIEN	XXXX	XXXX	XXX	XXX	XXXX	12
						CLAIM TOTAL	XXXX	XXXX	XXX	XXX	XXXXX	
CLAIM TYPE SUB-TOTAL				1			XXXX	XXXX	XXX	XXX	XXXXX	
PAID CLAIM TOTALS				1			XXXX	XXXX	XXXX	XXX	XXXXX	

REMINDER: CHECK #0123456789, ISSUED TO YOU MM/DD/YY FOR $2,618.67 REMAINS OUTSTANDING. PLEASE CASH THE CHECK OR CONTACT THE PROVIDER SERVICES UNIT IF THERE IS A PROBLEM.

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID	CLAIMS AMOUNT	WITHHELD AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	1	XXX.XX	00	00	XXXXX
YEAR - TO - DATE TOTAL	56	XXXX.XX	00	00	XXXXXX

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE

12 SERVICE PAID AT THE MAXIMUM AMOUNT ALLOWED BY MEDICAL ASSISTANCE REIMBURSEMENT POLICIES

Appendix 4
Reading the Remittance and Status Report

This appendix provides information about reading the Remittance and Status (R/S) Report.

Financial items and identifying information may appear on the R/S Report to acknowledge special transactions such as cash refunds made by the provider or any Medicaid check that is outstanding beyond 90 days. Pharmacy Point-of-Sale claims that were denied are not included on the R/S Report for Wisconsin Medicaid, BadgerCare, or SeniorCare.

Banner Page

The banner page provides important, time-sensitive information that may apply to all providers or to specific provider groups. The page may include messages about Medicaid-initiated adjustments, submission deadlines, and upcoming provider training sessions. Providers may also view the R/S messages on the Medicaid Web site.

Header Information

1H. Provider Name and Address
Indicates the name and address of the billing provider's payee as indicated on the Medicaid file. The payee's name and address is used for tax purposes on the 1099. (This is not necessarily the name of the billing provider.)

2H. R/S Number
Indicates the R/S Report number.

3H. Provider Number
Indicates the billing provider's eight-digit Medicaid provider number.

4H. Date
Indicates the date the R/S Report was printed.

5H. Page
Indicates the page number of the R/S Report. Information about the status of a claim generally starts on page 2.

6H. Report Seq Number
Indicates the number of R/S Reports the provider has received in the current calendar year.

Paid or Denied Claims Information

Review and verify the accuracy of individual claim and adjustment information to determine appropriate follow-up action — these are key items that could affect payment or denial.

1A. Patient Name
Indicates the recipient's last name and first name or first initial. The recipient's most current name on the Medicaid eligibility file always appears on the R/S Report. If the recipient has changed names, the name on the R/S Report may not be the name on the claim submitted by the provider.

2A. Patient Identification No.
Indicates the recipient's ten-digit Medicaid identification number.

3A. Medical Record No.
Indicates the first 18 characters of the recipient's medical record number as recorded on the Medicaid claim or adjustment request.

Appendix 4
(Continued)

4A. Patient Control Number
Indicates the recipient's account number as recorded on the Medicaid claim.

5A. Claim Number
Indicates the unique claim number assigned by Wisconsin Medicaid to the claim or adjustment.

6A. Service Dates
Indicates the dates of service (or date range) corresponding to the date(s) the service(s) were provided.

7A. UD (when applicable)
Gives the unit dose indicator as recorded on the Medicaid drug claim.

8A. NS (when applicable)
Gives the no substitute indicator as recorded on the Medicaid drug claim.

9A. Perf Prov/Rx Number (when applicable)
Indicates the performing provider number of the provider who performed the service or the prescription number.

10A. Days/Qty
Indicates the number of units, services, accommodation days, or supply quantity billed.

11A. Proc/Accom/Drug Cde/M1 M2 M3 M4
Provides the procedure code for the service(s) provided. Modifiers may also be indicated following the code.

12A. Procedure/Accommodation/Drug Description
Provides the procedure code description of the service(s) provided.

13A. Total Billed
Indicates the total billed charges for the service(s) shown on that line for claims or adjustments.

14A. Total Allowed
Indicates the Medicaid payment allowance (determined according to appropriate reimbursement criteria).

15A. Other Deducted Charges (when applicable)
Indicates the charges deducted from the total allowed for reasons such as other health insurance payment or patient liability (hospice and nursing home claims).

16A. Copay (when applicable)
Indicates the recipient Medicaid copayment amount deducted from total allowed amount.

17A. Paid Amount
Indicates the actual amount paid by Wisconsin Medicaid.

18A. EOB Codes
Indicates the numeric Explanation of Benefits (EOB) code(s) that is specific to Wisconsin Medicaid and corresponds to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail. A list of the EOB codes used, with their descriptions, appears on the last page of each R/S Report. The EOB code(s) that appears in the far right-hand column of the R/S Report explains either why that claim was paid as it was or why it was denied.

Appendix 4
(Continued)

1R. Reminder
Medicaid checks cannot be cashed after 180 days.

1P. Claims Payment Summary
Payment summary information follows.

2P. Claims Paid
a. Current Processed — Indicates the total number of claims and adjustments processed on this R/S Report.

b. Year-to-Date Total — Indicates the total number of claims and adjustments processed since the beginning of the calendar year.

3P. Claims Amount
a. Current Processed — Indicates the total dollar amount for the claims paid on this R/S Report.

b. Year-to-Date Total — Indicates the total actual amount for the claims paid since the beginning of the calendar year.

4P. Withheld Amount
a. Current Processed — Indicates the dollar amount of any withheld payments (e.g., negative adjustments) on this R/S Report.

b. Year-to-Date Total — Indicates the dollar amount of payments withheld (e.g., negative adjustments) since the beginning of the calendar year.

5P. Credit Amount
a. Current Processed — Indicates the dollar amount of any voluntary refunds dispositioned in the previous week.

b. Year-to-Date Total — Indicates the dollar amount of voluntary refunds dispositioned since the beginning of the calendar year.

6P. Net 1099 Amount
a. Current Processed — Indicates the net earnings for the claims shown on this R/S Report.

b. Year-to-Date Total — Indicates the net earnings calculated from the beginning of the calendar year.

Appendix 5

Reading Adjustments on the Remittance and Status Report

Paper Adjustments and Medicaid-Initiated Adjustments

The following provides information about reading the Remittance and Status (R/S) Report when a claim is adjusted because one of the following occurred:

- A paper adjustment request was submitted by the provider.
- Wisconsin Medicaid initiated an adjustment.

Original Claim — This is the original claim that was processed. The message "This is an adjustment to previous claim XXXXXXXXXXXXXXX paid on MMDDYY" indicates when the original claim processed. Information from the original claim follows. All items from the original claim appear with a minus sign in front of the dollar amounts.

Adjustment — This is the original claim plus the corrections requested by the provider or Wisconsin Medicaid. The claim number will indicate "19," "39," "49," or "59" as the claim type (the first two digits). Compare each detail from the original claim with each corresponding detail from the adjustment. If the adjustment is reimbursed at a greater amount than the original claim, additional reimbursement is made.

601 Receivable — If the adjustment is reimbursed at a lower amount than the original claim, an accounts receivable will be established. This is identified by "601 Receivable established for balance of $XXX.XX which will be withheld from future payments."

Electronic Adjustments

The following provides information about reading the R/S Report when a claim is adjusted because an electronic adjustment request was submitted by the provider.

Original Claim — This is the original claim that was processed. The message "This is an adjustment to previous claim XXXXXXXXXXXXXXX paid on MMDDYY" indicates when the original claim processed. Information from the original claim follows. All items from the original claim appear with a minus sign in front of the dollar amounts.

Adjustment — This is only the reprocessing of the original claim. The claim number will indicate "19," "39," "49," or "59" as the claim type (the first two digits).

New Claim — This is the original claim plus the corrections requested by the provider. The claim number will indicate the same claim type as the claim number from the original claim. Compare each detail from the original claim with each corresponding detail from the new claim. If the new claim is reimbursed at a greater amount than the original claim, additional reimbursement is made.

Appendix 6

Adjustment/Reconsideration Request Completion Instructions

(A copy of the Adjustment/Reconsideration Request Completion Instructions is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID

ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires the information supplied/requested on this form to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The Adjustment/Reconsideration Request, HCF 13046, is used by both Wisconsin Medicaid and SeniorCare to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

The Adjustment/Reconsideration Request is reviewed by Wisconsin Medicaid based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Providers should be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

The provider is required to maintain a copy of this form for his or her records.

INSTRUCTIONS

Type or print clearly. Enter the following information from the provider's Remittance and Status (R/S) Report or the 835 Health Care Claim Payment/Advice (835) transaction.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

Element 1 — Name — Billing Provider
Enter the billing provider's name.

Element 2 — Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit Medicaid provider number to which the claim was paid.

Element 3 — Name — Recipient
Enter the complete name of the recipient for whom payment was received.

Element 4 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number.

SECTION II — CLAIM INFORMATION

Element 5 — Remittance and Status (R/S) Report Date / Check Issue Date
Enter the date of the R/S Report or the check issue date from the 835 transaction showing the paid claim that the provider is adjusting.

Element 6 — Internal Control Number / Payer Claim Control Number
Enter the 15-digit internal control number (ICN) from the R/S Report or the payer claim control number from the 835 transaction of the paid or allowed claim. (When adjusting a previously adjusted claim, use the claim number assigned to the most recently processed claim or adjustment.)

Add a service line(s).
Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Element 7 — Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service (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 in the same month 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 December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 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(s), if applicable.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The billed amount for all procedures is identical.
- The number of services performed on each DOS is identical.
- All procedures have the same family planning indicator, if applicable.
- All procedures have the same emergency indicator, if applicable.

Element 8 — POS
Enter the appropriate two-digit POS code for each service.

Element 9 — Procedure / NDC / Revenue Code
Enter the single most appropriate procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code/national drug code/revenue code.

Element 10 — Modifiers 1-4
Enter the appropriate modifier(s).

Element 11 — Billed Amount
Enter the total billed amount for each line item. Providers are to indicate 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 12 — Unit Quantity
Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 13 — Family Plan
Enter an "F" for each family planning procedure.

Element 14 — EMG
Enter an "E" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 15 — Performing Provider
Enter the eight-digit Medicaid provider number of the performing provider for each procedure, if applicable.

SECTION III — ADJUSTMENT INFORMATION

Element 16 — Reason for Adjustment
Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire Medicaid payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the recipient was a nursing home resident on the DOS, the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Medicare remittance information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other / comments.* Add any clarifying information not included above.*

Element 17 — Signature — Provider**
Authorized signature of the provider.

Element 18 — Date Signed**
Use either the MM/DD/YY format or the MM/DD/YYYY format.

Element 19 — Claim Form Attached
Indicate if a corrected claim form is attached. Although this is optional, Wisconsin Medicaid encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

*If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.
**If the date or signature is missing on the Adjustment/Reconsideration Request Form, the adjustment request will be denied.

Appendix 7

Adjustment/Reconsideration Request Form (for photocopying)

(A copy of the Adjustment/Reconsideration Request form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13046 (Rev. 08/05)

WISCONSIN MEDICAID
ADJUSTMENT / RECONSIDERATION REQUEST

Instructions: Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, HCF 13046A, for information about completing this form.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Name — Billing Provider	2. Billing Provider's Medicaid Provider Number
3. Name — Recipient	4. Recipient Medicaid Identification Number

SECTION II — CLAIM INFORMATION

5. Remittance and Status (R/S) Report Date / Check Issue Date	6. Internal Control Number / Payer Claim Control Number

❑ Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).

7. Date(s) of Service		8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4				11. Billed Amount	12. Unit Quantity	13. Family Plan	14. EMG	15. Performing Provider
From	To			Mod 1	Mod 2	Mod 3	Mod 4					

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment

❑ Consultant review requested.
❑ Recoup entire Medicaid payment.
❑ Other insurance payment (OI-P) **$**_____.
❑ Copayment deducted in error ❑ Recipient in nursing home. ❑ Covered days _____. ❑ Emergency.
❑ Medicare reconsideration. (Attach the Medicare remittance information.)
❑ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
❑ Other / comments.

17. **SIGNATURE** — Provider	18. Date Signed
Mail to: Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002	19. Claim Form Attached (Optional) ❑ Yes ❑ No

Maintain a copy of this form for your records.

Appendix 8

Explanation of Benefits Codes That Qualify for Good Faith Claims Submission

The following table lists the only Explanation of Benefits codes and corresponding messages that qualify a denied claim for submission as a good faith claim.

Explanation of Benefits Code	Message
029	Recipient's Wisconsin Medicaid ID number does not match recipient's last name.
172	Recipient Medicaid number not eligible for date(s) of service.
252	Good Faith claim denied because of provider billing error.
281	Recipient Wisconsin Medicaid identification number is incorrect. Please verify and correct the number and resubmit claim.
293	Good Faith claim denied. Certifying agency did not verify recipient eligibility within 70-day period.
418	Good Faith claim has previously been denied by certifying agency. Resubmit claim with copy of a temporary ID card, EVS printed response, or indicate the AVR transaction log number.
614	Wisconsin Medicaid ID number does not match recipient's first name.

Appendix 9

Timely Filing Appeals Request Form (for photocopying)

(A copy of the Timely Filing Appeals Request form is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13047 (Rev. 08/05)

WISCONSIN MEDICAID
TIMELY FILING APPEALS REQUEST

Instructions: Type or print clearly.

The attached claim / adjustment meets one or more of the following criteria that are considered for late processing approval (check the appropriate statement[s]):

❑ Claim(s) denied for an eligibility-related explanation of benefits (EOB), reason, remark, or National Council for Prescription Drug Programs (NCPDP) reject code.
Claim number / payer claim control number, _____, originally processed on the Remittance and Status (R/S) Report or the 835 Health Care Claim Payment / Advice (835) transaction number _____, with the R/S Report / check issue date of _____ (attach R/S Report, if available, and one of the following items documenting eligibility: a copy of the magnetic stripe card reader printout, Automated Voice Response log number, or a copy of a paper temporary or Presumptive Eligibility card).

❑ Nursing home level of care / liability amount changes.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 transaction number _____, with the R/S Report / check issue date of _____ (R/S Report attached, if available).
New level of care _____.
New liability amount _____.

❑ Retroactive recipient eligibility for Wisconsin Medicaid (attach appropriate documentation for retroactive period, if available).

❑ Retroactive eligibility for general relief.

❑ Other insurance / Medicare recoupment (recoupment dated _____ attached).

❑ Medicare denial or reconsideration (reconsideration date _____ attached).

❑ Medicaid reconsideration.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 transaction number _____, with the R/S Report / check issue date of _____ (R/S Report attached, if available).

❑ Fair hearing decision, with signature dated _____ (complete copy attached).

❑ Court order, with signature dated _____ (complete copy attached).

Briefly explain the nature of the problem and previous efforts made to resolve the claims.

SIGNATURE — Provider	Date Signed

Continued

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Claims Submission section of the All-Provider Handbook and the applicable service-specific handbook for service restrictions and additional documentation requirements.

Attach the completed Timely Filing Appeals Request to the claim or adjustment form and attachments and submit them to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Timely Filing
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Appendix 10
Claim Refund Completion Instructions

(A copy of the Claim Refund Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID

CLAIM REFUND COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires the information indicated below to properly post a refund. Providers can submit either refunds or adjustment requests per payer control number (PCN) or internal control number (ICN), but should not do both. Adjustments must be submitted using the Adjustment/Reconsideration Request form, HCF 13046.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement.

Questions about refunds and other procedures or policies may be directed to Provider Services at (800) 947-9627 or (608) 221-9883. Mail this form to the address on the Claim Refund form, HCF 13066.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. Attach additional pages if more space is needed. Providers may photocopy the Claim Refund form for their own use.

INSTRUCTIONS

Type or print clearly.
Enter the following information from the provider's 835 Health Care Claim Payment/Advice (835) transaction or the Remittance and Status (R/S) Report.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

Element 1 — Payee / Billing Provider's Medicaid Provider Number
Enter the payee or billing provider's eight-digit Medicaid provider number to which the claim was paid.

Element 2 — Name — Payee / Billing Provider
Enter the payee or billing provider's name that corresponds to the provider number in Element 1.

Element 3 — Subscriber / Recipient Medicaid Identification Number
Enter the subscriber's or recipient's 10-digit Medicaid identification number.

Element 4 — Name — Subscriber / Recipient
Enter the complete name of the subscriber or recipient for whom payment was received.

SECTION II — CLAIM INFORMATION

Element 5 — Payer Control Number / Internal Control Number (15 digits)
Enter the PCN from the 835 transaction or the ICN from the R/S Report of the paid or allowed claim. (Use the claim number assigned to the most recently processed claim or adjustment.)

Element 6 — Check Issue Date / Report Date
Enter the check issue date from the 835 transaction or the date of the R/S Report showing the paid claim that the provider is refunding.

Element 7 — Date(s) of Service
Enter the month, day, and year for each procedure.

Element 8 — Procedure Code / National Drug Code / Revenue Code
Enter the procedure code for which the refund is being applied.

Element 9 — Modifiers 1-4
Enter the appropriate modifier(s).

Element 10 — Billed Amount
Enter the total billed amount for each line item.

Element 11 — Refund Amount
Enter the total refund amount for each line item.

Element 12 — Refund Total
Enter the total refund amount for the specific claim.

SECTION III — REFUND INFORMATION

Element 13 — Reason for Refund
Check the most appropriate box indicating the provider's reason for submitting the refund:

- *Medicare paid.*
- *Overpayment.*
- *Other commercial health or dental insurance payment.* Enter the amount paid by the other commercial health or dental insurance carrier.
- *Not our patient.*
- *Wrong date of service.*
- *Duplicate payment by Wisconsin Medicaid.*
- *Billing error.*
- *Other / comments.* Add any clarifying information not included above.

The provider is required to maintain a copy of this form for his or her records.

Appendix 11

Claim Refund Form
(for photocopying)

(A copy of the Claim Refund form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13066 (Rev. 08/05)

STATE OF WISCONSIN

WISCONSIN MEDICAID
CLAIM REFUND

Instructions: Type or print clearly.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Payee / Billing Provider's Medicaid Provider Number	2. Name — Payee / Billing Provider
3. Subscriber / Recipient Medicaid Identification Number	4. Name — Subscriber / Recipient

SECTION II — CLAIM INFORMATION

5. Payer Control Number / Internal Control Number	6. Check Issue Date / Report Date

7. Date(s) of Service		8. Procedure Code / National Drug Code / Revenue Code	9. Modifiers 1-4				10. Billed Amount	11. Refund Amount
From	To		Mod 1	Mod 2	Mod 3	Mod 4		
							12. Refund Total	

SECTION III — REFUND INFORMATION

13. Reason for Refund (check one)

- ❑ Medicare paid.
- ❑ Overpayment.
- ❑ Other commercial health or dental insurance payment (OI-P) $_____.
- ❑ Not our patient.
- ❑ Wrong date of service.
- ❑ Duplicate payment by Wisconsin Medicaid.
- ❑ Billing error.
- ❑ Other / comments.

Mail this form and either the Medicaid-issued check or provider-issued refund check to

Wisconsin Medicaid
Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

Maintain a copy of this form for your records.

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