Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies

Subject: New Claim Form; Place of Service, Type of Service and HCPCS Codes; and New Prior Authorization Request Form

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This bulletin should be used in conjunction with the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987.

I. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) has signed a new fiscal agent contract with E.D.S. Federal Corporation (EDS). Under this new contract, there will be major enhancements in the processing of Medical Assistance claims received by EDS on or after January 1, 1988. These enhancements are discussed in detail in the above referenced All Provider Bulletin.

In addition to the changes resulting from the new contract with EDS, the Health Care Financing Administration (HCFA) has mandated that all State Medical Assistance agencies implement use of a new claim form, the National Health Insurance Claim Form, HCFA 1500. The WMAP is implementing use of the National HCFA 1500 claim form for most providers. Many providers already use the Wisconsin version of the HCFA 1500 claim form to bill the WMAP and some are using the National HCFA 1500 claim form to bill Medicare and other third party payors. To facilitate consistent billing procedures, the WMAP is implementing the National HCFA 1500 claim form and national and local Place of Service and Type of Service codes.

Concurrent with the claim form change, the WMAP is also implementing the HCFA Common Procedure Coding System (HCPCS) currently used by Medicare. Use of HCPCS codes is also federally mandated.

NOTE: Due to the above mentioned changes, EDS will be converting the claims processing system at the end of 1987. Providers are advised to submit to EDS for receipt by no later than December 24, 1987, all claims, adjustments and prior authorization requests which are completed in accordance with billing instructions and claim forms in use in 1987. EDS will return, unprocessed, any claims received after December 24 which are in the 1987 format.

Past experience has shown that delivery of claims mailed during the holiday season is delayed due to heavy holiday mail. Please allow ample mailing time to ensure that claims mailed in 1987 are received no later than December 24. If there is a likely possibility that claims prepared and mailed in late December will not be received by EDS by December 24, it may be to the provider's advantage to hold such claims and mail them in the new format on or after January 1, 1988.

Providers are also advised that no checks will be issued on January 3, 1988. Claims which would have finalized processing during that week will appear on the following week's Remittance and Status Report.

II. PROVIDER BILLING WORKSHOPS

EDS is conducting provider workshops which focus on the WMAP requirements for the National HCFA 1500 claim form. These workshops are intended for billing personnel. See Attachment 10 for times and locations in your area.

III. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500

All Rehabilitation Agencies are required to use the National HCFA 1500 claim form for all claims received by EDS on or after January 1, 1988. Claims, including resubmission of any previously denied claims, received on a form other than the National HCFA 1500 claim form will be denied by EDS. Modifications to or use of modified versions of the National HCFA 1500 claim form may also result in claims denial.

A sample claim form and detailed billing instructions are included in Attachments 1 and 2 of this bulletin. Effective January 1, 1988, these instructions should be used to replace those currently included in the Rehabilitation Agency Provider Handbook, Part P, Division III, dated July 1, 1984. Providers should pay special attention to the following areas on the National HCFA 1500 claim form itself and to the changes in the type of information required for completion of the claim form.

1. Program Block (Claim Sort Indicator). A new element, the claim sort indicator, must be entered in the program block for Medicaid which is located on the top line of the claim form. This indicator identifies the general kinds of services being billed and is essential to processing of the claim form by EDS. Claim sort indicators for each type of service are included in the billing instructions. The sample claim form included in Attachment 1 indicates where on the claim form this information is to be entered. Claims received on or after January 1, 1988 without this claim sort indicator will be denied.

2. Element 1. The recipient's last name is required first, then the first name, and middle initial.

3. Element 6. The 10 digit Medical Assistance Recipient Identification Number must be entered.

4. Element 9. Revised "Other Insurance" (OI) disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

5. Element 10. This is an addition to the element which requests "other" accident information.

6. Element 11. Medicare disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

7. Element 24. There are two (2) fewer line items than on the current HCFA 1500 claim form.

8. Element 24H. Recipient spenddown amount, when applicable, must be entered in this element.

Providers should reference the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987, for additional details on claims processing changes.

Effective January 1, 1988, the National HCFA 1500 claim form will not be provided by either the WMAP or EDS. It is a national form that can be obtained at the provider's expense from a number of forms suppliers and other sources. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
MADISON WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (Toll free)

IV. PLACE OF SERVICE CODES

Claims received by EDS on or after January 1, 1988 must include national place of service (POS) codes in element #24B on the National HCFA 1500 claim form. Claims/adjustments submitted without POS codes or with incorrect POS codes will be denied. POS codes are listed on the back of the claim form. Allowable POS codes for Rehabilitation Agencies are included in Attachment 4.

V. TYPE OF SERVICE CODES

Effective January 1, 1988, the WMAP is converting currently used type of service (TOS) codes to coincide with the National TOS codes, which are located on the back of the National HCFA 1500 claim form, and with the additional codes used by Medicare and the WMAP. All providers are required to indicate the appropriate TOS code in element 24G on the claim form for each line item billed on all claims received on or after January 1, 1988. Claims/adjustments submitted without TOS codes will be denied. Claims/adjustments submitted with incorrect TOS codes are subject to incorrect reimbursement or denial. Allowable TOS codes for Rehabilitation Agencies are included in Attachment 4.

VI. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

The Health Care Financing Administration has also mandated state Medical Assistance agencies to use HCPCS. HCPCS is a procedure coding system that is currently used by Medicare.

HCPCS codes are composed of:

- Physician's Current Procedural Terminology - Fourth Edition (CPT-4) codes which are updated annually;
- Nationally assigned codes which are five (5) characters in length (alpha/numeric) and begin with any of the alpha characters A through V, e.g., A1234 - V5678; and
- Codes locally assigned by the WMAP or the Medicare Intermediary which are five (5) characters in length (alpha/numeric), and begin with the alpha characters W through Z, e.g., W1111 - Z9999.

HCPCS codes and their narrative descriptions are required on all claims/adjustments received by EDS on or after January 1, 1988. Claims/adjustments submitted without HCPCS codes and narrative descriptions will be denied. Allowable HCPCS codes and their descriptions for Rehabilitation Agencies are listed in Attachment 3.

VII. PRIOR AUTHORIZATION REQUEST FORM

The WMAP has developed a standard prior authorization (PA) request cover form for use by most providers. All Rehabilitation Agencies are required to use this form for all PA requests received by EDS on or after January 1, 1988.

The prior authorization request consists of two (2) parts, the standard prior authorization form, PA/RF, and the service specific attachment. Rehabilitation Agencies must request prior authorization for therapy services on the standard form, PA/RF, and on the therapy attachment, form PA/TA.

Spell of Illness requests must be requested on the standard form, PA/RF, and the Spell of Illness attachment for physical, occupational and speech therapy, form PA/SOIA. Prior authorization requests received on any other forms will be returned to the provider.

A Prior Authorization Request Form and Usage Table is included in Attachment 5.

Sample Prior Authorization request forms and detailed instructions for completing them are included in Attachments as follows:

	Attachment Numbers
Form PA/RF and Completion Instructions	6 - 6c
Form PA/TA and Completion Instructions	7 - 7c
Form PA/RF for Spell of Illness and Completion Instructions	8 - 8c
Form PA/SOIA and Completion Instructions	9 - 9d