Appendix 1
UB-92 Claim Form Instructions

Providers must use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless "optional" or "not required" is specified.

These instructions will help you complete a UB-92 claim only for Wisconsin Medicaid. If you need to submit a UB-92 claim to other payers in Wisconsin, you may want to refer to the UB-92 billing manual prepared by the State Unified Billing Committee (SUB-C). The UB-92 billing manual contains important coding information not available in this appendix.

Wisconsin Medicaid recipients receive an identification card when initially enrolled in Wisconsin Medicaid and at the beginning of each following month. Always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient information.

Item 1 - Provider Name, Address & Telephone Number
Enter the name, city, state, and zip code of the provider submitting the bill.

Item 2 - WIPRO Assigned Number (not required)

Item 3 - Patient Control Number (optional)
Providers can enter up to 17 characters of the patient's internal office account number. This number will appear on the provider's Remittance and Status Report.

Item 4 - Type of Bill
Enter the bill type code. Nursing homes billing for accommodations must indicate bill type 211, 212, 213, or 214.

Item 5 - Federal Tax Number (not required)

Item 6 - Statement Covers Period (from-through)
Enter the beginning and ending service dates for the period on this bill. Enter both dates in MMDDYY format (example: 010195|013195).

Item 7 - Covered Days
Enter the total number of days services were provided on this bill. Do not include the day of discharge.

Item 8 - Noncovered Days (not required)

Item 9 - Coinsurance Days (required for crossover claims)

Item 10 - Lifetime Reserve Days (not required)

Item 11 - Unlabeled Field (not required)

Item 12 - Patient Name
Enter the recipient's last name, first name, and middle initial exactly as it appears on the identification card.

Item 13 - Patient Address (not required)

Item 14 - Patient Birth Date (not required)

Item 15 - Patient Sex (not required)

Item 16 - Patient Marital Status (not required)

Item 17 - Admission Date
This is the date the recipient was admitted to the provider for inpatient care. Enter the admission date in the MMDDYY format (example: 010195). The date of admission to the nursing home is the first date the recipient enters the facility as an inpatient for the current residency. (Current residency is not interrupted by bedhold days or changes in level of care or payer status.)

Item 18 - Admission Hour (not required)

Item 19 -Type of Admission (not required)

Item 20 - Source of Admission
For bill type 211 and 212, enter the code describing the source of this admission.

Type of Bill Definitions

Type of Bill Code	Description
211	Inpatient nursing home - admit through discharge claim
212	Inpatient nursing home - interim, first claim
213	Inpatient nursing home - interim, continuing claim
214	Inpatient nursing home - interim, last claim

Code Structure for Source of Admission

Code	Title	Description
1	Physician referral	The recipient was admitted to this facility by the recommendation of his or her personal physician.
2	Clinic referral	The recipient was admitted to this facility by the recommendation of this facility's clinic physician.
3	HMO referral	The recipient was admitted to this facility by the recommendation of a health maintenance organization physician.
4	Transfer from a hospital	The recipient was admitted to this facility as a transfer from an acute care facility where the recipient was an inpatient.
5	Transfer from a skilled nursing facility	The recipient was admitted to this facility as a transfer from a skilled nursing facility where the recipient was an inpatient.
6	Transfer from another health facility	The recipient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities, and skilled nursing facility recipients that are at a non-skilled level of care.

7	Emergency room	The recipient was admitted to this facility by the recommendation of this facility's emergency room.
8	Court/law enforcement	The recipient was admitted to this facility by the direction of a court of law, or by the request of a law enforcement agency representative.
9	Information not available	The means by which this recipient was admitted to this facility is not known.

Item 21 - Discharge Hour (not required)

Item 22 - Patient Status
Enter the patient status code as of the "statement covers period" through date (item 6).

Code Structure for Patient Status

Code	Definition
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short-term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under care of a home IV provider.
20	Expired.
30	Still patient.

Item 23 - Medical/Health Record Number (optional)
Enter the number assigned to the patient's medical/health record. The medical/health record number is typically used to do an audit of the treatment history. It should not be substituted for the patient control number (item 3).

Items 24-30 - Condition Codes (required, if applicable)
Enter the code identifying a condition related to this claim.

Condition Code Structure for Insurance Codes

Code	Title	Definition
01	Military service related.	Medical condition incurred during military service.

02	Condition is employment related.	Recipient alleges that medical condition is due to environment/events resulting from employment.
03	Patient covered by insurance not reflected here.	Indicates that recipient/recipient representative has stated that coverage may exist beyond that reflected in this bill.
05	Lien has been filed.	Provider has filed legal claim for recovery of funds potentially due to a recipient as a result of legal action initiated by or on behalf of the recipient.

Item 31 - Unlabeled Field (not required)

Items 32-35 - Occurrence Codes and Dates (required, if applicable)

Code Structure for Occurrence Codes and Dates

Code	Title	Definition
01	Auto accident	Code indicating the date of an auto accident.
02	No fault insurance involved -- including auto accident/other	Code indicating the date of an accident including auto or other state has applicable no fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/tort liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
04	Accident/employment related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other accident	Code indicating the date of an accident not described by the above codes.
06	Crime victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

Item 36 - Occurrence Span Code and Date (not required)

Item 37 - Internal Control Number (ICN)/Document Control Number (DCN) (not required)

Item 38 - Responsible Party Name and Address (not required)

Items 39-41 - Value Codes and Amounts (required, if applicable)
Always enter value code 84 ("Medicaid patient liability amount") and the amount of any recipient liability.

Item 42 - Revenue Codes (required, if applicable)
Enter revenue code 001 on the line which has the total charges. This detail must have the total of all charges.

Item 43 - Revenue Description (date of service)
Enter the first date of service billed in MMDDYY format followed by a dash. Then enter the last date of

service being billed in MMDDYY format. If discharged, the last date of service is the discharge date.

Item 44 - HCPCS/Rate
Enter the appropriate accommodation or ancillary procedure code.

Item 45 - Service Date (not required)

Item 46 - Units of Service
Enter the number of days or quantity for each line item. Do not count or include the day of discharge/death for accommodation codes. The sum of the accommodation days must equal the billing period in item 43 and must equal the total days in item 7. For transportation services, enter the number of miles.

Item 47 - Total Charges (by accommodation/ancillary code category)
Enter the total charge for each accommodation and ancillary code. Indicate the total charges with 001 in item 42, the description in "total charges" in item 43, and the sum of all charges.

Item 48 - Noncovered Charges (not required)

Item 49 - Unlabeled Field (not required)

Item 50 - Payer Identification
Enter "T19 WI Medicaid." Identify all health insurance payers (including Medicare) on the identification card. Enter the results of billing each health insurance.

Item 51 - Provider Number
Enter the eight-digit billing provider number.

Item 52 - Release of Information Certification Indicator (not required)

Item 53 - Assignment of Benefits Certification Indicator (not required)

Item 54 - Prior Payments (required, if applicable)
Enter the amount the provider has received toward payment of this bill. If other insurance denied the claim, enter $0.00. (Do not include Medicare payments.) Enter the appropriate insurance indicator in item 84.

Item 55 - Estimated Amount Due (not required)

Item 56 - Unlabeled Field (not required)

Item 57 - Unlabeled Field (not required)

Item 58 - Insured's Name (not required)

Item 59 - Patient's Relationship to Insured (not required)

Item 60 - Certification/Social Security Number/Health Insurance Claim Identification Number
Enter the recipient's 10-digit identification number exactly as it appears on the identification card.

Item 61 - Insured's Group Name (not required)

Item 62 - Insured's Group Number (not required)

Item 63 - Treatment Authorization Code (required, if applicable)
Enter the approved seven-digit prior authorization number for all services requiring prior authorization (e.g.,

ventilator, AIDS, head injury). Do not attach the prior authorization to the claim.

Item 64 - Employment Status Code (not required)

Item 65 - Employer Name (not required)

Item 66 - Employer Location (not required)

Item 67 - Principal Diagnosis Code
Enter the full ICD-9-CM diagnosis code (up to five digits) for the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" codes.

Items 68-75 - Other Diagnosis Codes (optional)
Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Item 76 - Admitting Diagnosis
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Item 77 - External Cause of Injury Code (E-Code) (not required)

Item 78 - Race/Ethnicity (not required)

Item 79 - Procedure Coding Method Used (not required)

Item 80 - Principal Procedure Code and Date (not required)

Item 81 - Other Procedures Codes and Dates(not required)

Item 82 - Attending Physician ID
Enter the UPIN, eight-digit provider number, Wisconsin medical license number, or name of the attending physician.

Item 83 - Other Physician ID (not required)

Item 84 - Remarks (required, if applicable)
Bill health insurance before billing Wisconsin Medicaid, unless the service does not require health insurance billing, according to Appendix 18a of Part A of the provider handbook. If health insurance is a factor in processing this bill, enter the most appropriate "other insurance" code.

Code	When This Action Took Place
OI-P	PAID in part by other health insurance including HMO or HMP. The amount paid by the health insurance to the provider or insured is indicated on the claim.
OI-D	DENIED by other health insurance 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 in question was actually billed to and denied by the health insurer.

OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: ◆ recipient denies coverage or will not cooperate; ◆ the provider knows the service in question is Noncovered by the carrier; ◆ health insurance failed to respond to initial and follow-up claim; or ◆ benefits not assignable or cannot get assignment.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Bill Medicare for covered services prior to billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, and Medicare does not cover the service, indicate a Medicare disclaimer code.

Code	When This Action Took Place
M-1	**Medicare benefits exhausted**. This code applies when Medicare denied the claim because the recipient's lifetime benefit, spell of illness or yearly allotment of available benefits is exhausted.
M-5	**Provider not Medicare certified**. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or *cannot* be Medicare Part A or Part B certified.
M-6	**Recipient not Medicare eligible**. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility.
M-7	**Medicare disallowed or denied payment**. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice.
M-8	**Noncovered Medicare service**. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of noncovered Medicare services is in Appendix 16 of Part A, the all-provider handbook. Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

Items 85 and 86 - Provider Representative Signature and Date Bill Submitted

Sign and date the claim.