Podiatry Services Handbook

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State of Wisconsin

Department of Health and Family Services

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MEMORANDUM

DATE: February 24, 2003

TO: Podiatrists, Managed Care Organizations

FROM: Peggy B. Handrich, Administrator
Division of Health Care Financing

SUBJECT: New Podiatry Services Handbook

The Division of Health Care Financing (DHCF) is pleased to provide you with a copy of the new Podiatry Services Handbook.

All policies included in the handbook are effective for dates of service on and after May 1, 2003. Please utilize your current handbook, Part V, the Podiatry Handbook, until that date.

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The Podiatry Services Handbook incorporates current Medicaid podiatry policy information into a single reference source. The handbook replaces all prior podiatry services publications including Part V, the Podiatry Handbook, dated January 1992.

This handbook does *not* replace the All-Provider Handbook and all-provider *Wisconsin Medicaid and BadgerCare Updates*, the Wisconsin Administrative Code, or Wisconsin Statutes. Subsequent changes to podiatry services policies will be published first in *Wisconsin Medicaid and BadgerCare Updates* and later in the Podiatry Services Handbook revisions.

Additional Copies of Publications

All *Wisconsin Medicaid and BadgerCare Updates* and the Podiatry Services Handbook can be downloaded from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/.*

We would like to thank everyone who reviewed the handbook and provided comments.

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility:

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 5:00 p.m. (M-F)

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*Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation.

Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare Podiatry Services Handbook is issued to podiatrists that are Wisconsin Medicaid certified. It contains information that applies to fee-for-service Medicaid providers. The Medicaid information in the handbook applies to both Wisconsin Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

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Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

Handbook Organization

The Podiatry Services Handbook consists of the following chapters:

- General Information.
- Services.
- Preparing Claims.

In addition to the Podiatry Services Handbook, each Medicaid-certified podiatrist is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

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 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

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General Information

Provider Information

Scope of Service

The policies in the Podiatry Services Handbook govern services provided within the scope of practice of the profession as defined in s. 448.60(4), Wis. Stats.

The policies in the Podiatry Services Handbook govern services provided within the scope of practice of the profession as defined in s. 448.60(4), Wis. Stats.

Provider Eligibility and Certification

To become a Wisconsin Medicaid-certified podiatrist under HFS 105.265, Wis. Admin. Code, providers must be currently licensed to practice podiatry in Wisconsin, pursuant to s. 448.63(1), Wis. Stats., and registered under Pod. 4.01, Wis. Admin. Code.

Recipient Information

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Recipient Eligibility

Wisconsin Medicaid providers should verify recipient eligibility and identify any limitations to the recipient's coverage *before* providing services. Refer to the All-Provider Handbook for detailed information on accessing the Eligibility Verification System and eligibility for Wisconsin Medicaid. For telephone numbers regarding recipient eligibility, refer to the Important Telephone Numbers page at the beginning of this handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining podiatry services. Copayment amounts are determined per procedure code per date of service as listed in Appendix 6 of this handbook.

There is a $30.00 calendar year limit per recipient per provider for podiatry service copayments. For clinics with a billing provider number, the limitation is calculated per recipient per billing provider number instead of per recipient per performing provider number. For individual podiatrists billing under their own provider number and not under a clinic provider number, the limitation is per recipient per podiatrist.

Providers are reminded of the following copayment exemptions:

- Emergency services.
- Services covered by Wisconsin Medicaid HMOs and provided to HMO enrollees.
- Services provided to a pregnant woman if the services are related to the pregnancy.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.

The copayment must be collected from the recipient by the service provider. Applicable copayment amounts are automatically deducted by Wisconsin Medicaid from allowable payments.

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Services

In accordance with HFS 101.03(96m), Wis. Admin. Code, Wisconsin Medicaid only reimburses providers for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective.

Covered Podiatry Services

Covered podiatry services include those medically necessary services for the diagnosis and treatment of the feet and ankles as described in HFS 101-108, Wis. Admin. Code. Foot care is a covered service when the recipient's condition requires treatment by a podiatrist to ensure the health and safety of the recipient.

Wisconsin Medicaid reimburses podiatrists for procedures involving the tendons or muscles of the lower leg, provided the diagnosis or treatment relates to the feet. Claims for procedures performed by podiatrists which do not relate to the care of the foot and ankle are denied.

In accordance with HFS 107.14(b), Wis. Admin. Code, covered podiatry services include the following:

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- Evaluation and management services.
- Surgical procedures, including:
  - √ Multiple surgeries.
  - √ Routine foot care.
  - √ Mycotic procedures.
  - √ Casting/strapping/taping.
- Physical medicine.
- Laboratory.
- Radiology.
- Drugs/injections.
- Prescriptions for drugs.

Due to overlapping policy and coverage limitations between these categories of services, it is important to become familiar with all policies pertaining to covered podiatry services. Refer to Appendices 1 and 2 of this handbook for lists of allowable procedure codes for podiatrists.

Medical Necessity

In accordance with HFS 101.03(96m), Wis. Admin. Code, Wisconsin Medicaid only reimburses providers for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective.

"Medically necessary" means a medical assistance service under ch. HFS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Evaluation and Management Services

Evaluation and management (E&M) services include office visits, hospital visits, and consultations. Specific services include:

- Emergency room visits.
- Evaluations.
- Examinations.
- Home visits.
- Hospital visits.
- Nursing home visits.
- Preventive pediatric and adult health supervision.
- Treatments.

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Wisconsin Medicaid covers most of the categories of E&M services described in *Current Procedural Terminology* (CPT). Refer to Appendix 1 of this handbook for E&M procedure codes that Wisconsin Medicaid covers.

Podiatrists may perform and be reimbursed by Wisconsin Medicaid for certain E&M services provided to new or established patients in order to evaluate the need for podiatry services.

Established Patient

An established patient is one who has received professional services from the podiatrist or another podiatrist who belongs to the same group practice within the past three years.

New Patient

A new patient is defined as a patient who is new to the provider and whose medical and administrative records need to be established. A new patient has not received professional services from either the podiatrist or podiatrist's group practice within the past three years.

Office Located in Hospital

Providers should submit claims for services performed in a podiatrist's office which is located in an outpatient hospital facility with a place of service (POS) code "3" (office).

Office Visits and Counseling

Wisconsin Medicaid reimburses podiatrists for face-to-face office visits during which the podiatrist or the podiatrist's designee counsels a recipient as to available courses of treatment. Submit a claim for office counseling for the appropriate level E&M service (CPT procedure codes 99201-99215), even if counseling was the only service provided during the visit. This is true even if some of the possible courses of treatment discussed, and the one ultimately selected by the recipient, are not reimbursable under Wisconsin Medicaid.

Wisconsin Medicaid denies reimbursement for counseling services not identified as part of these E&M office visit procedure codes. Counseling provided to individuals to promote health and prevent illness or injury in the absence of symptoms or established illness (CPT procedure codes 99401-99404) is not reimbursable by Wisconsin Medicaid.

Wisconsin Medicaid does *not* cover procedure codes in the following CPT categories for podiatrists:

- Care plan oversight services.
- Case management services.
- Counseling and/or risk factor reduction intervention.
- Prolonged provider service without direct patient contact.
- Special E&M services.

Podiatrists may perform and be reimbursed by Wisconsin Medicaid for certain E&M services provided to new or established patients in order to evaluate the need for podiatry services.

Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, suture and cast removal, and postsurgical hospital and office visits.

Limitations Applicable to Evaluation and Management Procedure Codes

Evaluation and management procedure codes are separately reimbursable by Wisconsin Medicaid when billed in conjunction with physical medicine, laboratory/radiology, and drugs/injections. An E&M procedure is *not* separately reimbursable when performed on the same date of service (DOS) as routine foot care, mycotic procedures, surgery, or casting/strapping/taping. New and established E&M procedures are also *not* separately reimbursable for surgical procedures subject to preoperative and postoperative care restrictions, as reimbursement for the visit is included in the reimbursement for the surgical procedure.

Note: Wisconsin Medicaid does not recognize the CPT modifier "25."

Ancillary Providers

Wisconsin Medicaid covers services provided by dietary counselors, nutritionists, health educators, and other ancillary providers only if the services are provided under the direct, immediate, on-site supervision of a podiatrist as part of a podiatry E&M visit. It is not necessary for the podiatrist to have face-to-face contact with the recipient on every visit with an ancillary provider, except as dictated by good medical practice.

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"On-site" means that the supervising podiatrist is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The podiatrist is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Surgical Procedures

Allowable surgeries of the foot and ankle are covered services when performed by a podiatrist. Additional surgical procedures performed on the same foot within 90 days of the original surgery are paid at 50%.

Preoperative and postoperative care, office calls, and dressings are included in the reimbursement for the surgical procedure.

Claims for multiple surgical procedures performed for the same recipient on the same DOS must be submitted on the same claim form.

Podiatrists are reimbursed for multiple surgeries as follows:

- The first procedure listed on the claim is paid at 100% of the maximum allowable fee.
- The second procedure at 50%.
- The third procedure at 25%.
- The fourth and subsequent procedures at 13%.

Refer to Appendix 1 of this handbook for a list of allowable CPT and Healthcare Common Procedure Coding System (HCPCS) surgical procedure codes.

Limitations Applicable to Surgical Procedures

Certain surgical procedures are presumed to include a certain amount of preparatory and follow-up care. For this reason, reimbursement for up to three preoperative and varying postoperative days is included in reimbursement for certain surgical procedures. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, suture and cast removal, and postsurgical hospital and office visits. Claims for services which fall within the range of established pre- and postcare days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure. Surgical procedures are not reimbursable when a claim for a new or established patient E&M procedure code is submitted on the same DOS.

Routine Foot Care

Routine foot care is defined as the cleaning, trimming, cutting, and debridement of toenails, corns, and callouses.

To receive routine foot care, the recipient must be under the active care of a physician and have one of the following diagnoses:

- Arteriosclerosis obliterans evidenced by claudication.
- Blindness.
- Cerebral palsy.
- Cerebrovascular accident.
- Diabetes mellitus.
- Guillian-Barre syndrome.
- Multiple sclerosis.
- Parkinson's disease.
- Peripheral neuropathies involving the feet, which are associated with one of the following:
  - √ Malnutrition or vitamin deficiency.
  - √ Diabetes mellitus.
  - √ Drugs and toxins.
  - √ Multiple sclerosis.
  - √ Uremia.
- Polio.
- Scleroderma.
- Spinal cord injuries.

Refer to the Preparing Claims chapter of this handbook for claims submission procedures for routine foot care and to Appendix 2 of this handbook for allowable routine foot care procedure codes.

Limitations Applicable to Routine Foot Care

Routine foot care is allowable once per 61 days per recipient and is only reimbursable when provided to a Medicaid recipient with one of the specific diagnosis codes listed in Appendix 3 of this handbook. Claims for routine foot care must be submitted using the routine foot care procedure codes listed in Appendix 2 of this handbook, *not* a CPT code.

Routine foot care procedures are *not* reimbursable on the same DOS as a new or an established patient E&M procedure code. Do *not* use E&M procedure codes to submit claims for routine foot care services.

Mycotic Conditions and Mycotic Nails

Wisconsin Medicaid reimburses podiatrists for procedures associated with mycotic conditions and mycotic nails. Refer to Appendices 4 and 5 of this handbook for a list of Medicaid-allowable procedure codes and required diagnosis codes for mycotic conditions. Claims for mycotic procedures which indicate a diagnosis code not listed in Appendix 5 of this handbook may be monitored on a post-payment basis for appropriateness of care.

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Limitations Applicable to Mycotic Conditions and Mycotic Nails

Mycotic procedures are allowed a maximum of six times per year. Wisconsin Medicaid denies claims submitted in excess of this limit.

Casting/Strapping/Taping

Casting, strapping, and taping procedures are covered services when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains, and open wounds of the ankle, foot, and toes.

Wisconsin Medicaid does not reimburse for casting procedures that have the same DOS as a surgical procedure when the casting procedure is related to the surgery. These services are included in the reimbursement for the surgical procedure.

Refer to Appendix 1 of this handbook for allowable procedure codes for casting, strapping, and taping.

Routine foot care procedures are *not* reimbursable on the same DOS as a new or an established patient E&M procedure code.

Physical Medicine

The performance of physical medicine procedures by a podiatrist are limited to those procedures listed in Appendix 1 of this handbook, as stated in HFS 107.14(2)(d), Wis. Admin. Code.

Laboratory

A *written report* must be produced and maintained in the recipient's medical record when procedure codes with both technical and professional components are submitted with either a TOS "X" or "5."

Claims for laboratory services may be submitted by a podiatrist when necessary to treat an injury or disease related to the foot or ankle. A preparation or handling fee is allowed and may be reimbursed when billed by a podiatrist for a laboratory specimen sent to an outside laboratory. Refer to the Preparing Claims chapter of this handbook for billing procedures and limitations for laboratory handling fees and to Appendix 1 of this handbook for allowable laboratory procedure codes.

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Clinical Certification for Laboratory Services

Congress implemented the Clinical Laboratory Improvement Amendment (CLIA) to improve the quality and safety of laboratory services. CLIA requires all laboratories and providers performing tests for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards.

CLIA Enrollment

The federal Centers for Medicare and Medicaid Services (CMS) sends CLIA enrollment information to Wisconsin Medicaid. The enrollment information includes CLIA identification numbers for all current laboratory sites. Wisconsin Medicaid verifies that laboratories are CLIA certified before issuing a Medicaid provider billing number.

Further CLIA Information

For further information about CLIA regulations, the scope of CLIA, CLIA certification requirements, and how to become CLIA certified, refer to the Provider Certification section of the All-Provider Handbook which may be downloaded from Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/.*

Complete Procedure vs. Professional and Technical Components for Laboratory Services

Most laboratory services are performed and reimbursed as a complete procedure (type of service [TOS] "5"). Claims for laboratory procedures should be submitted as a complete procedure (TOS "5") when both the technical and professional components are performed by a single laboratory.

A *written report* must be produced and maintained in the recipient's medical record when procedure codes with both technical and professional components are submitted with either a TOS "X" or "5." If no written report is kept in the recipient's medical record, Wisconsin Medicaid will recoup for professional services upon audit.

At times, the technical component may be performed by the clinic, but the professional component is performed by an outside physician or laboratory. In these situations, each provider submits claims and is reimbursed only for the service performed, as follows:

- The provider performing the technical component indicates only the technical component (TOS "U").
- The provider performing the professional component indicates only the professional component (TOS "X"). Remember that the professional component must result in a written report that is kept in the recipient's medical record.

The complete procedure (TOS "5") is not reimbursable to either provider in this situation.

The attending physician's clinical interpretation of laboratory results is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the E&M service.

Radiology

Radiographs of the foot and ankle are covered podiatry services. Refer to Appendix 1 of this handbook for allowable radiology procedure codes.

Complete Procedure vs. Professional and Technical Components for Radiology Services

Podiatrists may be reimbursed for a complete procedure when performing both the professional and technical components of radiologic procedures, or supervising others who do so in the office, clinic, or other nonhospital setting (TOS "4," "6," or "K," as appropriate).

A *written report* regarding the analysis and interpretation of radiologic test results is required for Wisconsin Medicaid reimbursement of the professional component of radiologic services. This report must be kept as part of the recipient's medical record. If no written report is kept in the recipient's medical record, Wisconsin Medicaid will recoup for professional services upon audit.

If the POS is a hospital setting (inpatient, POS "1," or outpatient, POS "2"), or if the technical portion is performed by a portable X-ray provider, the clinic may be reimbursed for the professional component only, but not for the complete procedure. The technical component is reimbursed to the hospital or provider of portable X-ray services.

Podiatrists who perform only the technical component of radiologic services are reimbursed by Wisconsin Medicaid for the technical component only. The outside provider performing the professional component of the service is reimbursed only for the professional component.

Drugs/Injections

Podiatrists may dispense drugs or administer injections for the treatment of diseases or injuries of the foot and ankle, including mycotic conditions. For further information about Wisconsin Medicaid's coverage of drugs and injections, refer to the Pharmacy Handbook on the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/.*

Covered Procedure Codes

Wisconsin Medicaid covers the injectable drug procedure codes listed in the Physician Services Maximum Allowable Fee Schedule. Refer to Appendix 1 of this handbook for injectable drug "J," "Q," and "S" procedure codes, and to Appendix 2 of this handbook for reimbursable local (or "W") codes. The Physician Services Maximum Allowable Fee Schedule is available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/.* Providers may also purchase copies of the fee schedule from Wisconsin Medicaid. Copies are available on paper, microfiche, or diskette. Refer to the Claims Submission section of the All-Provider Handbook for ordering instructions.

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Reimbursement

Wisconsin Medicaid's reimbursement for the HCPCS "J," "Q," and "S" codes, local "W" drug codes, and the unclassified drug code ***includes*** reimbursement for the administration of the drug. Therefore, providers should not bill an injection administration code (i.e., CPT procedure codes 90782, 90783, 90784, and 90788) concurrently with a drug code or concurrently with any other injection administration code except as noted below.

To be reimbursed for an unclassified drug that does not require prior authorization (PA) or a covered "J," "Q," or "S" code that does not have a maximum allowable fee listed in the Podiatry Services Maximum Allowable Fee Schedule, podiatrists must submit a completed CMS 1500 claim form and attach the following information:

- Name of drug.
- National Drug Code (NDC).
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Wisconsin Medicaid's reimbursement for the HCPCS "J," "Q," and "S" codes, local "W" drug codes, and the unclassified drug code ***includes*** reimbursement for the administration of the drug.

Providers may be separately reimbursed for an injection administration code only when the medication is supplied and independently billed by a pharmacy using an applicable NDC, or when the recipient possesses and provides the medication for injection by a provider.

Vitamin B-12

Vitamin B-12 injections are covered only for the following diagnoses:

- Alcohol neuropathies.
- Anemia, post-gastrectomy syndrome.
- Anemia, megaloblastic.
- Anemia, fish tapeworm.
- Anemia, pernicious.
- Anemia, post-bowel resection.
- Anemia, macrocytic.
- Cancer of the stomach, liver, intestines, and colon.
- Strictures of the small intestine.
- Anastomosis or partial resection of the small intestine.
- Posterolateral sclerosis.
- Sprue or other malabsorption states.
- Blind loop syndrome.
- Crohn's disease.

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Corticosteroid Injections

Corticosteroid injections are limited to four injections per recipient per any rolling 365-day period, *unless* the recipient has one of the following diagnoses:

- Neoplasms.
- Endocrine, nutritional, and metabolic diseases and immune disorders.
- Diseases of blood and blood-forming organs.
- Multiple sclerosis.
- Other demyelinating diseases of the central nervous system.

Except as otherwise provided in federal or state law, a prescription must be in writing, or given orally and later reduced to writing by the provider filling the prescription.

Other Injections

Estrogen and estrone injections are limited to four per recipient per any 365-day period.

Prescriptions for Drugs

Wisconsin Medicaid covers both legend and certain over-the-counter (OTC) drugs. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Medicaid coverage for some drugs is restricted by diagnosis code or prior authorization. Drugs that are identified by the Food and Drug Administration (FDA) as less-than-effective (LTE) or as identical, related, or similar to LTE drugs are not covered by Wisconsin Medicaid. Drugs identified on the Wisconsin Negative Formulary are also not covered.

For further information regarding Wisconsin Medicaid coverage of drugs, contact Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883.

General Prescription Requirements

It is vital that podiatrists provide adequate documentation for the pharmacy or other providers to fill a prescription for a legend or OTC drug. Except as otherwise provided in federal or state law, a prescription must be in writing, or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- Date of the order.
- Name and address of the prescriber.
- Name and address of the recipient.
- Prescribed drug or item and directions for use.
- Prescriber's signature and date.

For hospital and nursing home recipients, prescriptions must be entered into the medical and nursing charts, and must include the above information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills which are valid for shorter periods of time. Providers must maintain the yearly prescription(s) in the recipient's medical record, otherwise Wisconsin Medicaid will recoup for these drugs upon audit.

Prescribing Brand-Name Legend Drugs

Wisconsin Medicaid reimburses a pharmacy for a brand-name drug at the same rate allowed for a generic equivalent unless the prescriber certifies that the brand-name drug is medically necessary and documents the medical necessity in the recipient's medical record. This requirement applies only to legend drugs.

Prescribers must write the phrase "BRAND MEDICALLY NECESSARY" or "MEDICALLY NECESSARY" on the prescription. (Phrases like "NO SUBSTITUTES" or "N.S." are not acceptable.) This certification must be in the prescriber's own handwriting directly on the prescription order or on a separate order which is attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescribing provider does not satisfy this requirement.

A letter of certification is acceptable as long as the notation is handwritten, is for specified drugs for an individual recipient, and is valid for not more than one year. A "blanket" authorization for an individual recipient, drug, or prescriber is not acceptable.

For recipients in nursing homes, prescriber certification that the brand is medically necessary must be made on each prescription order written. This certification is valid only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

While it is the responsibility of pharmacies to have this documentation before submitting their claims to Wisconsin Medicaid, it is the prescriber's responsibility to provide a pharmacy with the required documentation.

The "Brand Medically Necessary" provisions described for legend drugs do not apply to covered OTC drugs. Medicaid coverage for OTC drugs is limited to generic drugs except for the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

Drug manufacturers who choose to participate in state Medicaid programs are required to sign a rebate agreement with the federal CMS under the drug rebate program. By signing the rebate agreement, the manufacturer agrees to pay Wisconsin Medicaid a rebate equal to a percentage of its "sales" to Wisconsin Medicaid.

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Wisconsin Medicaid does not cover drugs of companies choosing not to sign the rebate agreement with few exceptions. A Medicaid-certified pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement. In addition, providers may refer to the Pharmacy Data Tables section of the Pharmacy Handbook for a list. Providers may reference the Pharmacy Handbook on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Wisconsin Medicaid recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer who has not signed a rebate agreement. These drugs may be covered when the pharmacy obtains PA.

Providers must maintain the yearly prescription(s) in the recipient's medical record, otherwise Wisconsin Medicaid will recoup for these drugs upon audit.

Medicaid's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient.

In this situation, the prescriber must provide the following documentation to the pharmacy:

- A statement indicating that no other drug produced by a manufacturer that signed the rebate agreement is medically appropriate for the recipient.
- A statement indicating that Medicaid reimbursement of the drug would be cost effective for Wisconsin Medicaid.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber documenting medical necessity. Refer to the Pharmacy Handbook and the All-Provider Handbook for PA information.

Over-the-Counter Drugs

Wisconsin Medicaid covers limited categories of OTC drugs. Wisconsin Medicaid covers the *generic* products of specific OTC drug categories from manufacturers who have signed rebate agreements with CMS (as required by the Omnibus Budget Reconciliation Act of 1990 [OBRA '90]). All OTC drugs require legal prescriptions in order to be covered by Wisconsin Medicaid.

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Compound Drugs

Wisconsin Medicaid covers a particular compound drug only when the compound prescription:

- Contains more than one ingredient.
- Contains at least one Medicaid-covered legend drug.
- Does not contain any drug listed on the Medicaid LTE Drug List or any equivalent or similar drug.
- Does not result in drug combinations that the FDA considers LTE.

Wisconsin Medicaid does not cover compound prescriptions intended for therapeutic use if the FDA does not approve the therapeutic use of the combination.

Drug Utilization Review System

The federal OBRA '90 (42 CFR Parts 456.703-456.705) called for a Drug Utilization Review (DUR) program for all Medicaid outpatient drugs to improve the quality and cost-effectiveness of recipient care. Medicaid's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient.

Prescribers may see an increase in the number of inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Noncovered Services

According to HFS 107.14(3), Wis. Admin. Code, the following services are not covered if performed by a podiatrist:

1. Procedures which do not relate to the diagnosis or treatment of the ankle or foot.
2. Palliative or maintenance care, except as defined as covered routine foot care under "Covered Podiatry Services" in this chapter.
3. All orthopedic and orthotic services, except plaster and other material cast procedures and strapping or tape casting for treating fractures, dislocations, sprains, or open wounds of the ankle, foot, or toes.
4. Orthopedic shoes and supportive devices, such as arch supports, shoe inlays, and pads.
5. Physical medicine exceeding the limits specified in HFS 107.14(2)(d), Wis. Admin. Code.
6. Repairs made to orthopedic and orthotic appliances.
7. Dispensing and repairing corrective shoes.
8. Services directed toward the care and correction of "flat feet."
9. Treatment of subluxation of the foot.
10. All other services not specifically identified as covered in this handbook.

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Preparing Claims

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

Claims Submission Process

All claims, whether electronic or paper, are subject to the same Wisconsin Medicaid processing and legal requirements.

Electronic Claims Submission

All providers, including podiatrists are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both claims submission and processing errors.

Wisconsin Medicaid provides free software for electronic claims submission. For more information about electronic claims submission:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

Providers who are currently using the free software and have technical questions should contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claims Submission

Providers submitting paper claims must use the CMS 1500 claim form (dated 12/90). Appendix 8 of this handbook contains a completed sample of a CMS 1500 claim form for podiatry services. Refer to Appendix 7 of this handbook for CMS 1500 claim form completion instructions.

Wisconsin Medicaid denies claims for podiatry services submitted on any other paper claim form than the CMS 1500 claim form.

Wisconsin Medicaid does not provide the CMS 1500 claim form. Providers may obtain the form from any vendor who supplies federal forms.

Where to Send Your Claims

Mail completed CMS 1500 claim forms to the following address:

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

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claims submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at *www.dhfs.state.wi.us/medicaid/*.

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge and the maximum allowable fee established by the Department of Health and Family Services, less any third party payments.

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

To obtain a maximum allowable fee schedule for podiatry services, providers may:

- Download an electronic version from Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.

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- Purchase a paper fee schedule by using the order form located in the Claims Submission section of the All-Provider Handbook or by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Documentation Requirements

Provider's should record the following information in the recipient's record when providing a service:

- Recipient's full name.
- Date of service.
- Performing provider's name, title, and signature.
- An accurate, complete, and legible description of each service provided.
- The purpose and need for the service.

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Claim Components

Procedure Codes

Use the single five-character *Current Procedural Terminology* (CPT) procedure code, Healthcare Common Procedure Coding System (HCPCS) code, or approved local procedure code that best describes the service performed. Wisconsin Medicaid denies claims received without an appropriate CPT, HCPCS, or local code. Refer to Appendices 1 and 2 of this handbook for a list of Medicaid-allowable podiatry procedure codes.

Do not use multiple procedure codes to describe a single service.

Diagnosis Codes

All claims submitted for podiatry services must include an appropriate diagnosis code from the *International Classification of Diseases, Ninth Edition, Clinical Modifications* (ICD-9-CM) coding structure. Wisconsin Medicaid denies claims received without an appropriate ICD-9-CM coding structure. Refer to Appendices 3 and 5 of this handbook for the appropriate diagnoses for routine foot care and mycotic procedure codes.

Refer to the Provider Resources section of the All-Provider Handbook for information about ordering the ICD-9-CM code book.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Medicaid a higher fee for the same service than that charged to a private-pay patient. For providers who have not established usual and customary charges, the usual and customary fee should be reasonably related to the cost of providing the service.

Specific Instructions for Podiatry Services

Routine Foot Care

A referring physician is not required to be indicated on the claim when submitting claims for routine foot care, but the name of the primary or attending physician must be documented in the recipient's medical record. When routine foot care services include multiple digits on either one or both feet, Wisconsin Medicaid reimburses a single fee for the service.

A referring physician is not required to be indicated on the claim when submitting claims for routine foot care, but the name of the primary or attending physician must be documented in the recipient's medical record.

If routine foot care is performed in the nursing home for several nursing home recipients on the same date of service (DOS), the podiatrist must indicate the procedure code W9102 (First patient, nursing home visit) for a single recipient. Wisconsin Medicaid will reimburse the normal maximum allowable fee for an established patient visit for this recipient. Claims for all other recipients seen in the nursing home on that DOS must be submitted indicating the procedure code W9103 (Subsequent patients, nursing home visit), and they will be reimbursed at a reduced rate. Providers should submit a separate claim for each recipient seen on the same DOS.

Bilateral Surgeries

Bilateral surgical procedures are paid at 150% of the maximum fee for the single service. Indicate modifier "50" in Element 24D and a quantity of "1.0" in Element 24G of the CMS 1500 claim form. Refer to the list of allowable procedure codes in Appendix 1 of this handbook that indicates which procedures may be billed as bilateral surgical procedures.

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Bilateral surgical procedures are paid at 150% of the maximum fee for the single service.

Laboratory Tests

Podiatrists may be reimbursed for laboratory tests billed as a "complete" procedure or for the professional component only. A complete laboratory test includes both the professional and technical components.

Laboratory Tests and Preparation Fees

If a podiatrist obtains a specimen and refers it to an outside laboratory for analysis or interpretation only, the outside laboratory may be reimbursed for the complete procedure. In this instance, the podiatrist may submit claims only for a laboratory handling fee using the handling fee procedure code.

If a podiatrist performs both the professional and technical components of a laboratory test, the podiatrist may be reimbursed for the complete procedure. In this instance, a handling fee is not allowable.

Additional limitations on submitting claims for handling fees are as follows:

1. One laboratory handling fee is reimbursable to a podiatrist per recipient, per outside laboratory, per DOS, regardless of the number of specimens sent to the laboratory. A laboratory handling fee is allowable only when "yes" is indicated in Element 20 of the CMS 1500 claim form.
2. When submitting claims for handling fees for specimens sent to two or more laboratories for one recipient on the same DOS, indicate the number of laboratories in the units field in Element 24G of the CMS 1500 claim form and the total charges in Element 24F of the CMS 1500 claim form.
3. Wisconsin Medicaid denies claims for a laboratory handling fee that do not have "yes" checked for the outside laboratory in Element 20 of the CMS 1500 claim form.
4. The DOS for a laboratory handling fee must be the date the specimen is taken.

Clinical interpretations of laboratory tests are not separately reimbursable, since interpretations are reimbursed in the payment for the patient/podiatrist visit.

McKesson ClaimCheck® Monitors Medicaid Policy

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to CPT codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

For further information about ClaimCheck, refer to the Medicine and Surgery section of the Physician Services Handbook.

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Appendix

Appendix 1
Allowable Podiatry Services CPT and HCPCS Procedure Codes

Refer to the following charts for allowable podiatry services Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. These charts are periodically revised. Refer to Appendix 6 of this handbook for applicable TOS codes and descriptions.

Service	Type of Service	*Current Procedural Terminology* (CPT) Codes
Surgery	2	10060-10061, 10120-10180, 11000-11001, 11040-11043, 11055-11057*, 11100-11101, 11200-11201, 11300-11311, 11400-11426, 11620-11626, 11719*, 11720-11765, 11900-11901, 12001-12005, 12020, 12041-12044, 13160, 15000, 15050-15261, 15350, 15400, 15786-15787, 16000-16010, 17000-17250, 20000-20005, 20103, 20200-20205, 20520-20525, 20550, 20600-20605, 20670-20680
	2, 8	20816
	2	20924, 27603-27630
	2, 8	27637
	2	27638, 27647-27703, 27707, 27808-27823, 27830-27871, 28001-28288, 28289-28299*, 28300-28360, 28400*, 28405-28530, 28540-28635, 28645-28665, 28675-28760, 28810-28825, 29305-29445, 29450*, 29505-29515, 29540-29580, 29700-29740, 29750*, 29799
	8	29891-29892
	2, 8	29893*
	2	64450
Radiology	4, Q, U	73600-73610
	4, Q	73615
	4 Q, U	73620-73660
Pathology and Laboratory	5	81000-81015, 81025-81099, 82108, 82310-82330, 82728, 83015
	5, U, X	83715
	X	83912
	5	84100, 84550, 85007, 85009, 85014-85041, 86316-86318
	5, U, X	86329-86332
	5	87001-87045, 87070, 87075-87076, 87081-87106, 87109-87147, 87158
	5, U, X	87164-87166
	5	87176-87184, 87186-87197, 87205-87206
	5, U, X	87207
	5	87210-87253, 87260-87272, 87274, 87276, 87278, 87280, 87285-87299, 87301-87324, 87328-87335, 87340, 87350-87391, 87420-87425, 87430-87450, 87470-87799
	5, U, X	87999
	5	88230-88239, 88245-88248, 88263, 88269, 88283, 88289
	5, X	88358-88362
	5	88365

*** May be billed as a bilateral procedure with modifier "50" in Element 24D of the CMS 1500 claim form.**

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Appendix

Service	Type of Service	CPT Codes
Medicine	1	90782, 90788, 97010-97139
	5	99000-99001
	1	99070, 99199
Evaluation and Management	1	99201-99203, 99211-99213, 99221-99222, 99231-99232, 99234-99239
	3	99241-99242, 99251-99252, 99261-99262
	1	99281, 99301-99316, 99341-99350, 99499

Service	TOS	HCPCS* codes
Medical and Surgical Supplies	9	A4490-A4510, A6244
Drugs Administered Other Than Oral Method	1	J0120, J0170-J0270, J0280, J0290-J0295, J0350-J0390, J0456-J0470, J0500-J0585, J0600-J0630, J0640, J0690, J0696-J0704, J0710-J0743, J0745-J0850, J0900-J1051, J1060-J1250, J1320-J1438, J1450, J1455-J1560, J1564-J1565, J1580-J1630, J1642-J1750, J1785, J1800, J1815, J1825-J1830, J1840-J1890, J1940-J1955, J1960-J2000, J2150-J2270, J2275-J2352, J2360-J2370, J2405-J2543, J2550-J2765, J2780-J2790, J2800, J2910-J2912, J2920-J2930, J2950-J2995, J3000, J3030-J3070, J3105-J3364, J3370, J3400-J3480, J3490-J3520, J7030-J7050, J7060-J7191, J7194, J7198-J7199, J7310, J7501, J7504-J7505, J7507-J7510, J7516, J7599, J7699-J8499, J8530-J8999
Chemotherapy Drugs	1	J9000-J9150, J9165-J9170, J9181-J9182, J9190-J9211, J9213-J9218, J9230-J9260, J9266, J9270-J9293, J9320-J9999
Q Codes (Temporary)	P	Q4029-Q4048
Temporary National Codes (Non-Medicare)	1	S0009, S0016-S0078, S0080-S0081
	5	S3645-S3650
	4, Q, U	S8035

*HCPCS = Healthcare Common Procedure Coding System.

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Appendix 2
Allowable Podiatry Services Local Codes

Refer to the following charts for allowable podiatry services local codes.

All Codes Have Type of Service "1"		
Service Category	**Code**	**Description**
Injections	W6100	Injection, acth gel, 80 units
	W6102	Injection, ampicillin, 1 gm
	W6104	Injection, bicillin cr, 900/300
	W6105	Injection, bicillin cr, up to 300,000 units
	W6106	Injection, calcimar, 100 units
	W6107	Injection, calcimar, 200 units
	W6109	Injection, calcium chloride, 10 ml
	W6110	Injection, cleocin, up to 600 mg
	W6112	Injection, cortrosyn, 0.25 mg
	W6114	Injection, depo-medrol, 60 mg
	W6115	Injection, depo-medrol, 120 mg
	W6120	Injection, dexamethasone, la 8 mg/ml
	W6121	Injection, dexamethasone, la 16 mg
	W6122	Injection, dextrose, 50 ml
	W6124	Injection, ephedrine
	W6126	Injection, furosemide, 20 mg
	W6127	Injection, furosemide, 40 mg
	W6128	Injection, furosemide, 80 mg
	W6130	Injection, glucagon, 1 mg
	W6134	Injection, heparin, 10,000 units
	W6136	Injection, heparin, 20,000 units
	W6137	Injection, heparin, 5,000 units
	W6138	Injection, hydrocortisone, 250 mg
	W6140	Injection, imferon, 1 ml
	W6141	Injection, imferon, 3 ml
	W6142	Injection, isoproterenol
	W6144	Injection, kantrex, 1 gm
	W6146	Injection, kefzol, 1 gm
	W6148	Injection, magnesium sulfate
	W6152	Injection, nubain
	W6156	Injection, penicillin g procaine, 900,000 units
	W6157	Injection, penicillin g procaine, 1.2 mil units
	W6158	Injection, penicillin g procaine, 2.4 mil units
	W6159	Injection, penicillin g procaine, 4.8 mil units
	W6160	Injection, penicillin g procaine, 2.4 mil units/probe

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All Codes Have Type of Service "1"		
Service Category	**Code**	**Description**
Injections (continued)	W6161	Injection, penicillin g procaine, 4.8 mil units/probe
	W6162	Injection, procaine
	W6168	Injection stadol
	W6170	Injection susphrine
	W6172	Injection tensilon, 5 mg
	W6173	Injection terramycin, 100 mg
	W6175	Tine/mantoux/ppd
	W6177	Injection velban, 2 mg
	W6178	Injection velban, 5 mg
	W6179	Injection velosef, 250 mg
	W6180	Injection velosef, 500 mg
	W6181	Vistaril, 100 mg
Routine foot care	W9100	New patient, office visit
	W9101	Established patient, office visit
	W9102	First patient, nursing home visit
	W9103	Subsequent patients, nursing home visit
	W9104	New patient, patient's residence
	W9105	Established patient, patient's residence

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Appendix 3
Required Routine Foot Care Diagnosis Codes

Refer to the following charts for a list of required routine foot care *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes.

ICD-9-CM Diagnosis Code	Description
250.6	Diabetes with neurological manifestations
250.7	Diabetes with peripheral circulatory disorders
250.8	Diabetes with other specified manifestations
333.7	Symptomatic torsion dystonia
335	Anterior horn cell disease
335.0	Werdnig-Hoffmann disease
335.1	Spinal muscular atrophy
335.10	Spinal muscular atrophy, unspecified
335.11	Kugelberg-Welander disease
335.19	Other
335.2	Motor neuron disease
335.20	Amyotrophic lateral sclerosis
335.21	Progressive muscular atrophy
335.22	Progressive bulbar palsy
335.23	Pseudobulbar palsy
335.24	Primary lateral sclerosis
335.29	Other
335.8	Other anterior horn cell diseases
335.9	Anterior horn cell disease, unspecified
336	Other diseases of spinal cord
336.0	Syringomyelia and syringobulbia
336.1	Vascular myelopathies
336.2	Subacute combined degeneration of spinal cord in diseases classified elsewhere
336.3	Myelopathy in other diseases classified elsewhere
336.8	Other myelopathy
336.9	Unspecified disease of spinal cord
337	Disorders of the autonomic nervous system
337.0	Idiopathic peripheral autonomic neuropathy
337.1	Peripheral autonomic neuropathy in disorders classified elsewhere
337.9	Unspecified disorder of autonomic nervous system
340	Multiple sclerosis
341	Other demyelinating diseases of central nervous system
341.0	Neuromyelitis optica
341.1	Schilder's disease
341.8	Other demyelinating diseases of central nervous system
341.9	Demyelinating disease of central nervous system, unspecified

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Appendix 3
(Continued)

ICD-9-CM Diagnosis Code	Description
342	Hemiplegia and hemiparesis
343	Infantile cerebral palsy
343.0	Diplegic
343.1	Hemiplegic
343.2	Quadriplegic
343.3	Monoplegic
343.4	Infantile hemiplegia
343.8	Other specified infantile cerebral palsy
343.9	Infantile cerebral palsy, unspecified
344	Other paralytic syndromes
344.1	Paraplegia
353	Nerve root and plexus disorders
353.0	Brachial plexus lesions
353.1	Lumbosacral plexus lesions
353.2	Cervical root lesions, not elsewhere classified
353.3	Thoracic root lesions, not elsewhere classified
353.4	Lumbosacral root lesions, not elsewhere classified
353.5	Neuralgic amyotrophy
353.6	Phantom limb (syndrome)
353.8	Other nerve root and plexus disorders
353.9	Unspecified nerve root and plexus disorder
355	Mononeuritis of lower limb
355.0	Lesion of sciatic nerve
355.1	Meralgia paresthetica
355.2	Other lesion of femoral nerve
355.3	Lesion of lateral popliteal nerve
355.4	Lesion of medial popliteal nerve
355.5	Tarsal tunnel syndrome
355.6	Lesion of plantar nerve
355.7	Other mononeuritis of lower limb
355.8	Mononeuritis of lower limb, unspecified
355.9	Mononeuritis of unspecified site
356	Hereditary and idiopathic peripheral neuropathy
356.0	Hereditary peripheral neuropathy
356.1	Peroneal muscular atrophy
356.2	Hereditary sensory neuropathy
356.3	Refsum's disease

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ICD-9-CM Diagnosis Code	Description

for current policy

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Appendix

Appendix 4
Allowable Surgical Procedure Codes for Mycotic Conditions

Refer to the following chart for a list of allowable surgical *Current Procedural Terminology* (CPT) codes for mycotic conditions.

CPT Procedure Code	Description
10060	Incision and drainage of abcess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abcess, cyst, furuncle, or paronychia); simple or single
10061	complicated or multiple
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface
11001	each additional 10% of body surface
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion
11101	each separate/additional lesion
11720	Debridement of nail(s) by any method(s); one to five
11721	six or more
11730	Avulsion of nail plate, partial or complete, simple; single
11732	each additional nail plate
11750	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
17003	second through 14 lesions, each
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

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Appendix 5
Allowable Diagnosis Codes for Mycotic Conditions and Mycotic Nails

Refer to the following chart for a list of allowable *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for mycotic conditions and mycotic nails.

ICD-9-CM Diagnosis Code	Description
039	Actinomycotic infections
039.4	Madura foot
110.1	Dermatophytosis of nail
110.4	Dermatophytosis of foot
111	Dermatomycosis, other and unspecified
111.0	Pityriasis versicolor
111.1	Tinea nigra
111.2	Tinea blanca
111.3	Black piedra
111.8	Other specified dermatomycoses
111.9	Dermatomycosis, unspecified
112	Candidiasis
112.3	Candidiasis of skin and nails
116	Blastomycotic infection
116.0	Blastomycosis
116.1	Paracoccidioidomycosis
116.2	Lobomycosis
117	Other mycoses
117.0	Rhinosporidiosis
117.1	Sporotrichosis
117.2	Chromoblastomycosis
117.3	Aspergillosis
117.4	Mycotic mycetomas
117.5	Cryptococcosis
117.6	Allescheriosis (Petriellidosis)
117.7	Zygomycosis (Phycomycosis or Mucormycosis)
117.8	Infection by dematiacious fungi, (Phaehyphomycosis)
117.9	Other and unspecified mycoses
118	Opportunistic mycoses
703.8	Other specified diseases of nail

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Appendix 6
Copayment Amounts and Allowable Podiatry Type of Service and Place of Service Codes

Refer to the following charts for copayment amounts and allowable podiatry type of service and place of service codes.

Podiatry Services Copayments*	
Medicaid Maximum Allowable Fee	**Copayment**
Office visits. Each service costing:	
• Up to $10.00	$0.50
• From $10.01 to $25.00	$1.00
• From $25.01 to $50.00	$2.00
• Over $50.00	$3.00
Each surgery	$3.00
Each laboratory service	$1.00
Each X-ray service	$3.00
Routine foot care	$1.00
* A $30 calendar year copayment limit per year, per recipient, per provider applies.	

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Type of Service Codes	
Code	**Description**
1	Medical
2	Surgical
3	Consultation
4	Total charge — diagnostic X-ray or ultrasound
5	Total charge — diagnostic laboratory
B	Total charge — diagnostic medical
Q	Professional component — diagnostic X-ray or ultrasound
U	Technical component — diagnostic X-ray or ultrasound
W	Technical component — diagnostic medical
X	Professional component — diagnostic laboratory

Place of Service Codes	
Code	**Description**
1	Inpatient hospital
2	Outpatient hospital
3	Office
4	Home
7	Nursing home
8	Skilled nursing facility
B	Ambulatory surgical center

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Appendix 7
Completion Instructions for the CMS 1500 Claim Form

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should always verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator
Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if the recipient is male or female by placing an "X" in the appropriate box.

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Element 4 — Insured's Name (not required)

Element 5 — Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name
Third-party insurance (commercial health insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial health insurance, and the service requires third-party billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes must be indicated in the first box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by 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 was actually billed to the commercial health insurer.

Appendix

OI-Y YES, the recipient has commercial health insurance, but it was not billed for reasons including, but not limited to:

- The recipient denied coverage or will not cooperate.
- The provider knows the service in question is not covered by the carrier.
- The recipient's commercial health insurance failed to respond to initial and follow-up claims.
- Benefits are not assignable or cannot get assignment.

When the recipient is a member of a commercial HMO, one of the following must be indicated, if applicable:

Code	Description
OI-P	PAID by commercial HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important note: The provider may not use OI-H if the commercial HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the first box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

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Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The non-physician provider's Wisconsin Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes may be used when appropriate:

Code **Description**

M-1 **Medicare benefits exhausted.** This code may be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

M-5 **Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for a date of service (DOS) before or after their Medicare certification effective dates. Use M-5 in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

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M-7 **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 **Noncovered Medicare service.** This code may be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.

- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

When appropriate, enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

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Element 19 — Reserved for Local Use

If the provider bills an unlisted (or not otherwise specified) procedure code, the provider must describe the procedure. If Element 19 does not provide enough space for the procedure description, or if the provider is billing multiple unlisted procedure codes, the provider must attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19. Do not bill unlisted procedure codes through electronic billing. Unlisted procedure codes are required to be submitted through paper claims submission.

Element 20 — Outside Lab?

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise this element is not required.

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- 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 charge for all procedures is identical. (Enter the total charge per detail line in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B — Place of Service
Enter the appropriate Medicaid single-digit POS code for each service.

Element 24C — Type of Service
Enter the appropriate Medicaid single-digit TOS code for each service.

Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Claims received without an appropriate procedure code are denied by Wisconsin Medicaid.

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Modifiers
Enter the appropriate two-character modifier in the "Modifier" column of Element 24D. Use modifier "50" to indicate a bilateral procedure. Please note that Wisconsin Medicaid has not adopted all CPT, HCPCS, or Medicare modifiers.

Element 24E — Diagnosis Code
Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges
Enter the total charge for each line item.

Element 24G — Days or Units
Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24I — EMG
Enter an "E" for each procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use
Enter the eight-digit Medicaid provider number of the performing provider for each procedure, if the billing provider indicated in Element 33 belongs to a physician clinic or group.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.
Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge
Enter the total charges for this claim.

Element 29 — Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.) Do not enter Medicare-paid amounts in this field.

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Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier
The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered
If the services were provided to a recipient in a nursing home, indicate the nursing home's eight-digit Wisconsin Medicaid provider number.

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 8
Completed Sample of the CMS 1500 Claim Form

APPROVED OMB-0938-0008

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** — SEX M **X** F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): **609 Willow**

CITY: **Anytown** — STATE: **WI**

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

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): **OI-P**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? YES NO PLACE (State)
c. OTHER ACCIDENT? YES NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

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14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. **726.90**
2. **735.4**
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.

	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	MM DD YY		3	1	99202		1 2	XX XX	1				
2	MM DD YY		3	4	73620		1 2	XX XX	2				
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ **XXX XX**

29. AMOUNT PAID $ **XX XX**

30. BALANCE DUE $ **XX XX**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *IMAuthorized* DATE **MM/DD/YY**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# — GRP# **87654321**

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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Glossary of Common Terms

Adjustment
A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed claim
A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare
BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

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CMS
Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

CPT
Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

Crossover claim
A Medicare-allowed claim for a dual entitlee submitted to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF
Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS
Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS
Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS
Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee
A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual.

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid provider of the status or action taken on a claim.

EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

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Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services (DHFS) to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as HCFA Common Procedure Coding System.

HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a given provider type and the maximum allowable fee and relative value units (RVUs) Wisconsin Medicaid assigns to each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a service that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
   1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
   2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Payee

Party to whom checks are made payable. The payee's address is used as the mailing address for checks and Remittance and Status (R/S) Reports.

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POS

Place of service. A single-digit code which identifies the place where the service was performed.

QMB Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. These recipients are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

Qualifying circumstances

Conditions that complicate the rendering of anesthesia services, including the extraordinary condition of the patient, special operative conditions, and unusual risk factors.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

RVU

Relative value unit. A number assigned by Wisconsin Medicaid to indicate the relative clinical intensity and difficulty of the surgical, diagnostic, or therapeutic procedure code for which anesthesia services were performed. Relative value units are not necessarily equivalent to either federal or American Society of Anesthesiologists RVUs. Relative value units are indicated on the Physician Maximum Allowable Fee Schedule.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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