COVERAGE DETERMINATION SOFTWARE (CDS) *revised 1/1/2000*

All Medicaid-certified providers receive coverage determination software (CDS) upon certification and are required to use it for recipients who are eligible for both Medicare and Wisconsin Medicaid. This computer software helps providers identify when they should bill Medicare before billing Wisconsin Medicaid for dually eligible recipients. It also allows you to access help screens which explain Medicare home health policy. The printed results from the CDS determination provide documentation to meet the federal requirement that services covered by Medicare are not paid by Wisconsin Medicaid.

Home health and personal care agencies are required to use the CDS for recipients who are eligible for both Medicare and Wisconsin Medicaid. Requirements are reviewed below:

- Use the CDS before your agency provides Wisconsin Medicaid services.
- Use the CDS when a recipient's condition or status changes, making the recipient potentially eligible for Medicare coverage.
- Keep a printed copy of the results of the software's determination on file and on the agency's premises for audit purposes.

If you are unable to access the CDS with your computer system or have computer problems, you can use the Worksheet for Home Health Coverage Determination Questions from this manual to reach the same results. Photocopy the final eligibility determination from Appendix B of this manual. Keep a copy of the completed worksheet and the final eligibility determination in your files.

Further Information

Technical questions about the software should be directed to:

United Wisconsin Proservices, Inc.
401 W. Michigan Street
Milwaukee, WI 53203

Telephone: (800) 822-8050
Fax: (414) 226-6033

Policy and billing questions should be directed to:

Medicaid Provider Services
(800) 947-9627 or (608) 221-9883

Windows NT users

If you use a Windows NT operating system, you will *not* be able to use the CDS software print option. In this situation, you may complete the worksheet from this manual instead of using the software. A Windows-NT compatible version of the CDS software will be available to providers in the future.

Coverage Determination Software:

This Coverage Determination Software (CDS) was developed by Wisconsin Medicaid as a tool to assist in determining whether Medicare should be billed prior to Medicaid for home care services provided to dually eligible recipients. The software does not represent all Medicare policy regarding home care services and does not guarantee payment by either Medicare or Medicaid.

Personal care agencies can contact the Division of Health Care Financing with questions regarding home care policy. The source of Medicare-related material within this software is the Medicare Home Health Agency Manual, U.S. Department of Health and Human Services, Health Care Financing Administration, April 1996 and Transmittal Number A97-12, September 1997.

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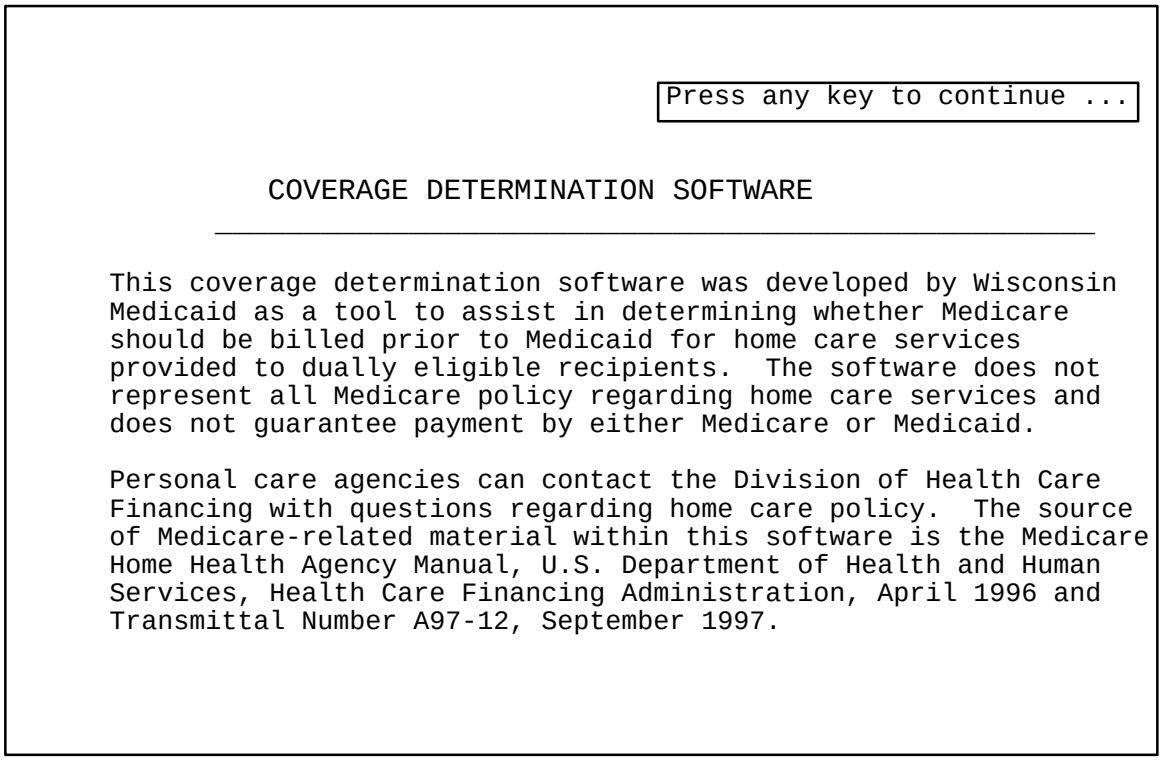
Starting the Wisconsin Medicaid Coverage Determination Software

To use this software, you will need a 386 processor or faster PC with DOS or WINDOWS 3.1 or higher.

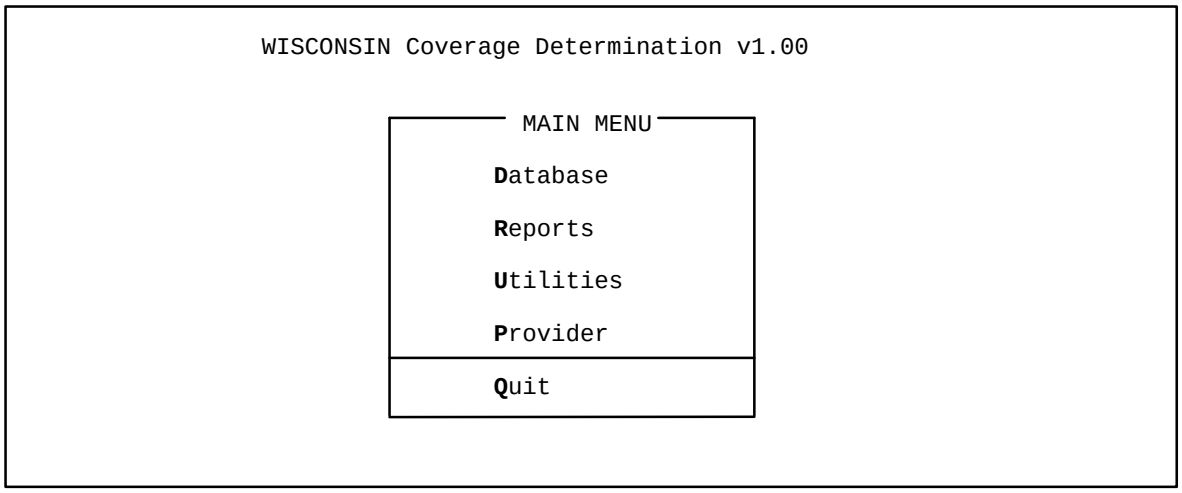
After installation, start the Coverage Determination Software (CDS) by **typing CDS at the C:\ prompt** or as directed by your information systems department.

After the software loads, the first screen will appear. After reading this message, **press any key to enter the Main Menu of the work area.**

Please use the flowchart in Appendix A as a helpful guide when reading this manual.



The Main Menu screen appears.



From this menu, choose from the following options:

Database - This option allows you to enter new patient information or to retrieve existing patient information in the database to use in determining coverage.

Reports - This option allows you to print an alphabetical patient listing and/or a qualifier code list.

Utilities - This option allows you to rebuild the index file of the database.

Provider - This option allows you to enter your agency information.

Quit - This option closes the software.

Following are the screens that display for each option.

Database

This option allows you to enter or access patient records and proceed with the coverage determination on the Database Screen. The screen appears below. Basic patient information can be entered and displayed. Options that appear at the right of the screen allow you to:

Add - Enter a new patient record.

Edit - Retrieve an existing patient record from the database.

Next - Move forward through the database records after retrieving an existing patient record to check for duplicate records or to select a different patient.

Prior - Move backward through the database records after retrieving an existing patient record.

Search - Search for a patient record. You may simply enter the first letter of the last name and browse through existing records or enter the entire last name to find the matching record.

P**r**ovider - Display the provider information.

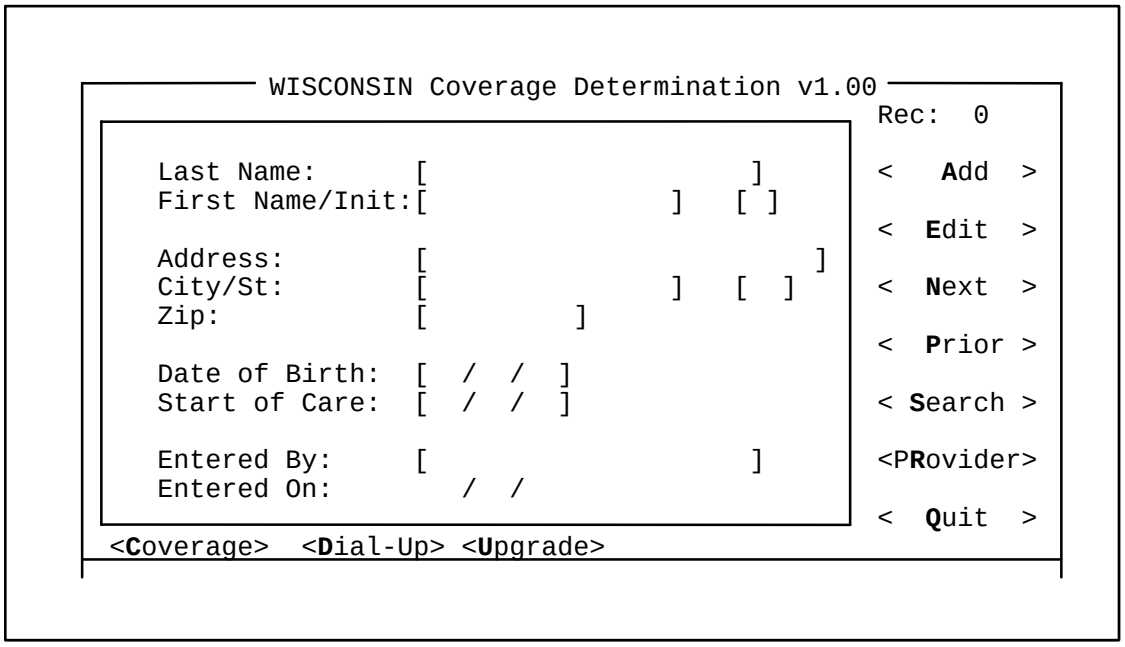
Quit - Close the software.

At the bottom of the screen additional choices are shown.

Coverage - Takes you to the coverage determination section.

Dial-Up - Is reserved for future use and not functional at this time.

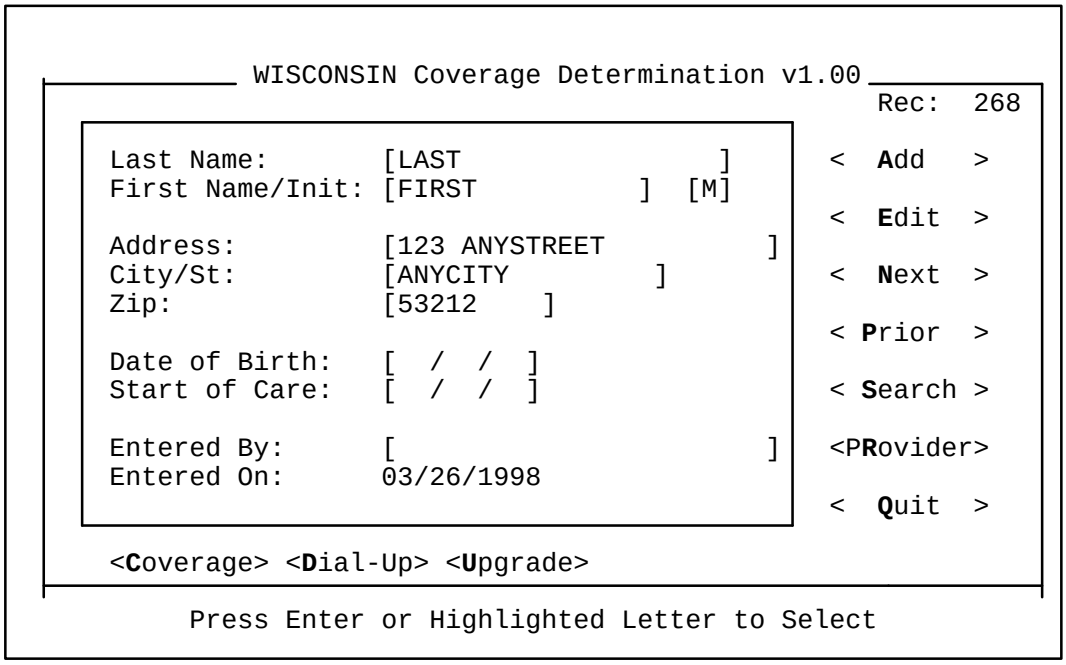
Upgrade - Allows for future upgrades of the software.



When **S**earch is selected, the following screen appears. A prompt pops up (not pictured below) which allows you to enter information for searching. You may fill in the entire last name of the patient or just the first letter of the last name. When you have done this, select OK to continue with the search or Cancel to return to the Database Screen.

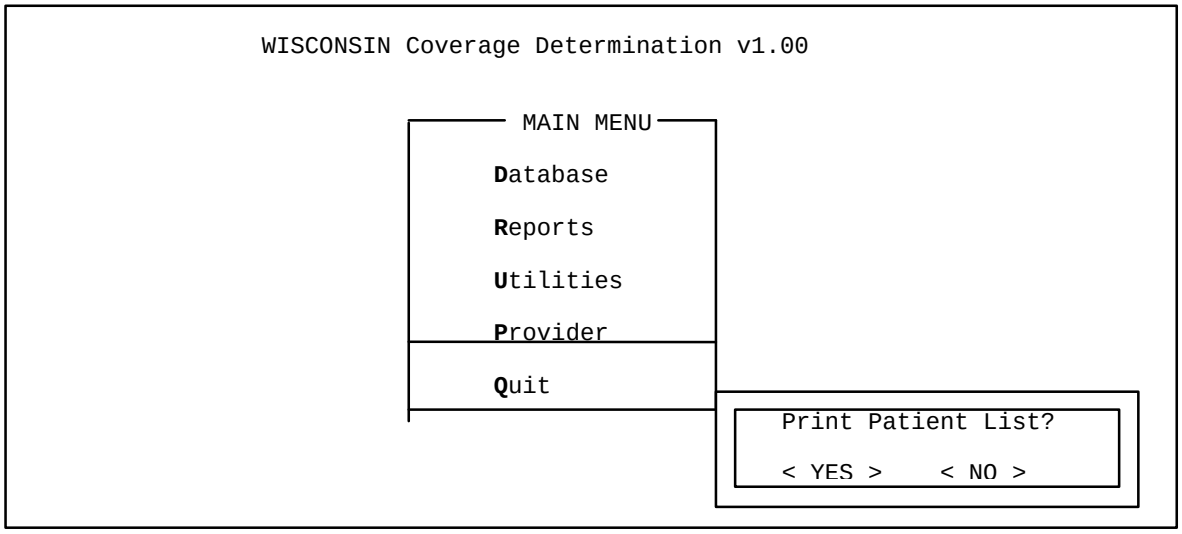
When you select **S**earch, a matching record is retrieved from the database and the information will fill in as on the screen below.

You may now **E**dit the record or proceed to **C**overage determination.

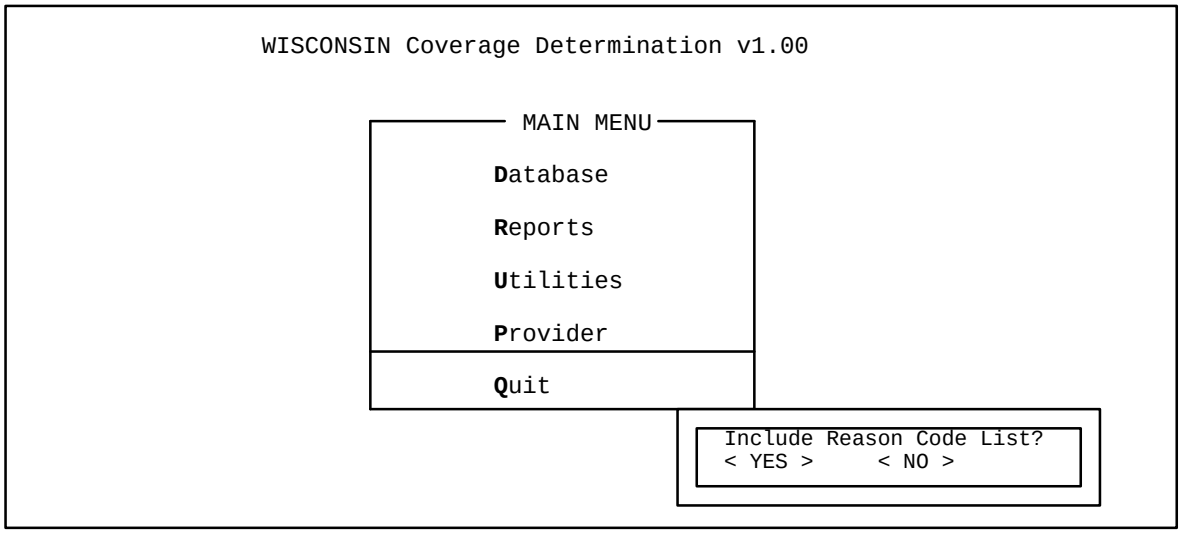


Reports

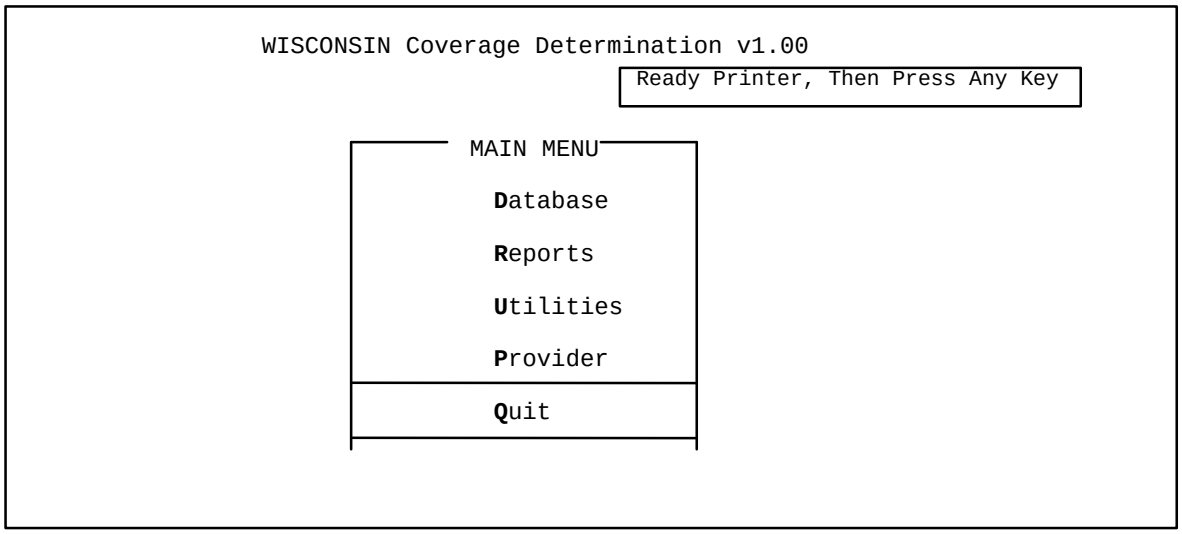
When **R**eports is selected, a prompt pops up to ask if you want to print a patient list (see screen below).



If you answer NO to print the patient list, you will return to the Main Menu screen. If you answer YES, a listing of patients will print out in alphabetical order. A second menu will then pop up. It will ask if you want to print out the list of qualifier codes and reasons (see Appendix C for a listing of qualifier codes). If you select YES, the reports will print out automatically. If you select NO, you will be returned to the Main Menu.



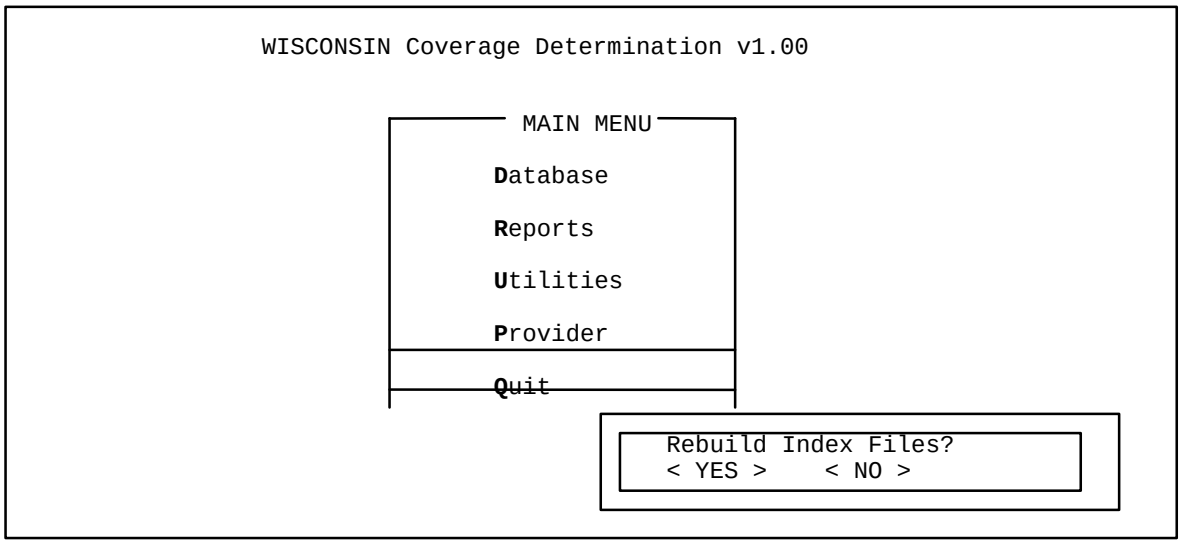
This screen appears, allowing you time to ready your printer (make sure that it is turned on, has sufficient paper, etc.). Select YES when you are ready to print.



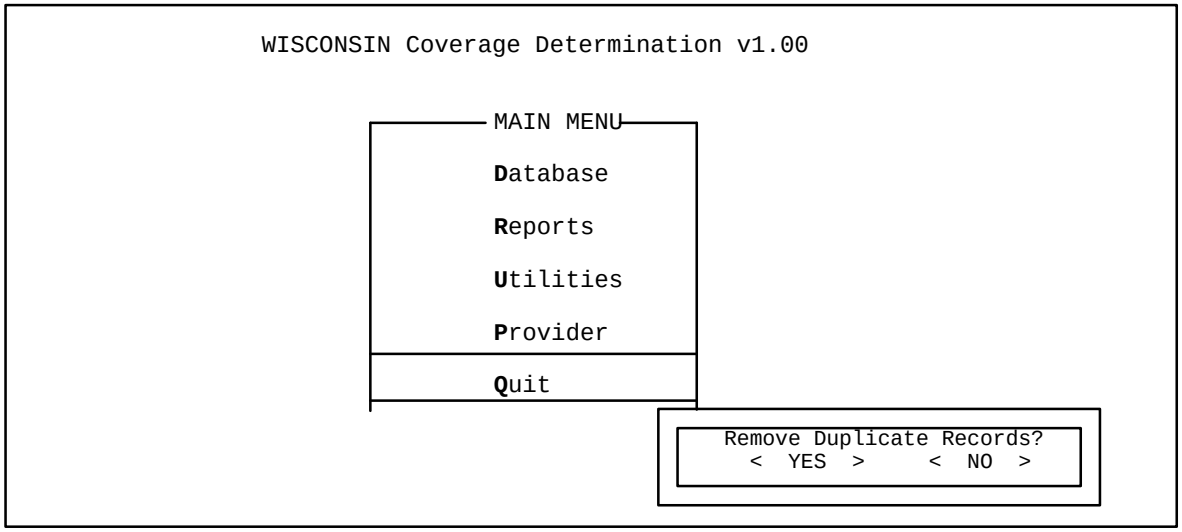
The reports you have selected will print.

Utilities

When **U**tilities is selected, you are asked if you want to rebuild the index file of the master patient list for the database.

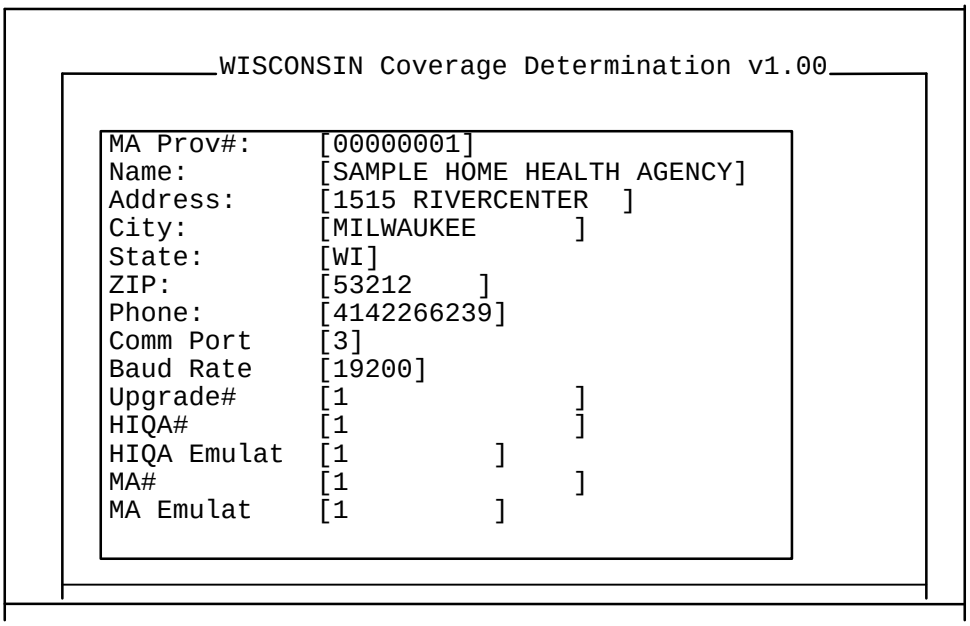


Answer YES or NO. If you answer YES, a message will pop up and ask if you want to remove any duplicate records. If you answer YES, the system will perform the selected task then return you to the Main Menu. If you choose NO, you will be returned to the Main Menu screen.



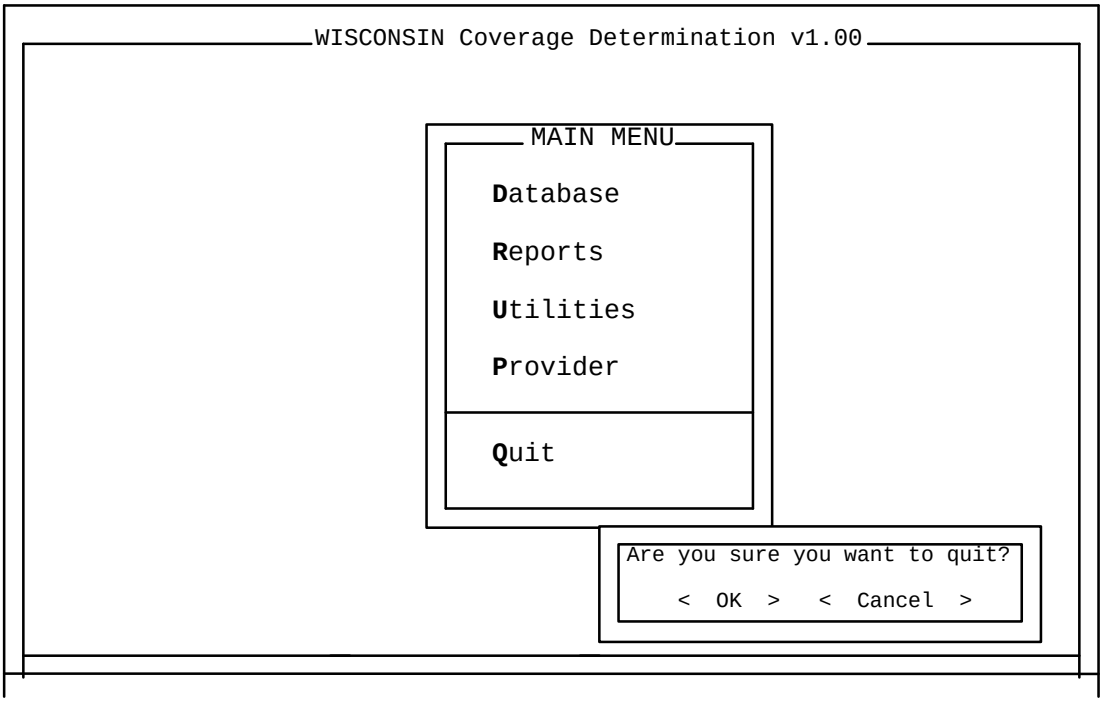
Provider

Choosing this option allows you to enter and maintain information specific to your agency. This information includes your Wisconsin Medicaid provider number, name, full address, and phone number. The remaining fields on this screen are reserved for future use. After entering data, press the **F10** key to save the information and return to the Main Menu. Press the ESC key to return to the Main Menu without making any changes.



Quit

If you choose this option, a message will pop up to verify that you want to exit the software. Select NO to return to the Main Menu screen. Select YES to close the software package.



WORKSHEET FOR HOME HEALTH COVERAGE DETERMINATION QUESTIONS

The following worksheet can be used if the CDS is unavailable.

Last Name _____
First Name _____ Middle Initial_____

Address _____
City _____ State _____
ZIP _____

Medicaid Identification Number _____
Date of Birth _____
Medicare Start of Care _____

Entered by _____

(1) Valid Medicare Card ( ) Yes ( ) No Medicare ID#_____

If the answer is no, end of questions. The patient must be dually eligible for Medicare/Medicaid to qualify for the coverages determined in this program. If yes, continue with question 2.

(2) Is the recipient eligible for:
( ) Part A
( ) Part B

(3) Valid Medicaid Card ( ) Yes ( ) No Medicaid ID#_____

If the answer is no, end of questions. The patient must be dually eligible for Medicare/Medicaid to qualify for the coverages determined in this program. If yes, continue with question 4.

(4) Is the recipient homebound?
( ) Yes
( ) No

If the answer is no, go to question 10. If yes, go to question 5.

(5) Does the recipient need Medicare-covered physical therapy, speech therapy or continuous occupational therapy?

( ) Yes
( ) No

If the answer is yes, go to question 9. If no, go to question 6.

(6) Does recipient need Medicare–covered skilled nursing (SN) fewer than seven days a week or less than eight hours of each day for periods of 21 days or less, with extension in exceptional circumstances when the need for additional care is finite and predictable?

( ) Yes
( ) No

If the answer is yes, go to question 9. If no, go to question 7.

(7) Does recipient need SN fewer than seven days a week for long term care for any Medicare-covered services?
( ) Yes
( ) No

If the answer is yes, go to question 9. If no, go to question 8.

(8) Is SN (up to and including several visits per day, seven days per week) needed long term for a recipient who is physically or mentally unable to self-administer insulin and there is no willing or able caregiver?

( ) Yes
( ) No

If yes, go to question 9. A no answer results in a determination of Medicare-INELIGBLE (screen 9, see Appendix B, page 1 to photocopy). End of questions.

(9) Does recipient need assistance with activities of daily living and/or other covered home health aide services?

( ) Yes
( ) No

A yes answer results in a determination of Medicare-ELIGIBLE (screen 12, see Appendix B, page 3 to photocopy). A no answer results in a determination of Medicare-ELIGIBLE (screen 11, see Appendix B, page 2 to photocopy). End of questions.

(10) Can recipient reasonably obtain services elsewhere?
( ) Yes
( ) No

A yes answer results in a determination of Medicare-INELIGIBLE (screen 8, see Appendix B, page 1 to photocopy). A no answer results in a determination of Medicare-INELIGIBLE. Recipient also does not meet Wisconsin Medicaid requirements for home health services (screen 10, see Appendix B, page 2 to photocopy). End of questions.

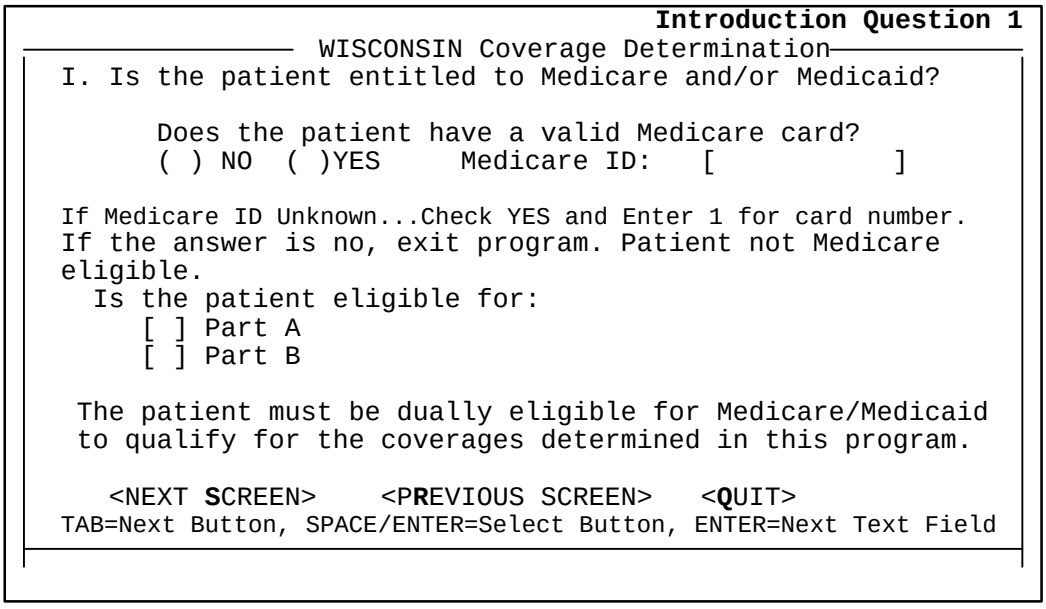
Coverage Determination Questions

Instructions at the bottom of the screen show you how to move around the screen. You can move from field to field by pressing the tab key; you can select an item by pressing the space bar or enter; or you can accept an answer and move to the next field on the screen by pressing enter. Press the highlighted letter of any command to launch the command. Press **F12**, then select CANCEL to exit and shut down the software without saving any changes.

The Introduction Question 1 screen, shown below, appears when **C**overage is selected (from the Database Menu). This screen allows you to confirm and enter the Medicare ID number. If this record is for an existing patient, the Medicare ID field will have information from the database. If the record is incorrect or blank, you can enter the correct Medicare ID. If the Medicare ID is unknown at this time, you may still continue with coverage determination by entering a 1 in that field. You may then edit the record at any time in the future to enter the correct Medicare ID.

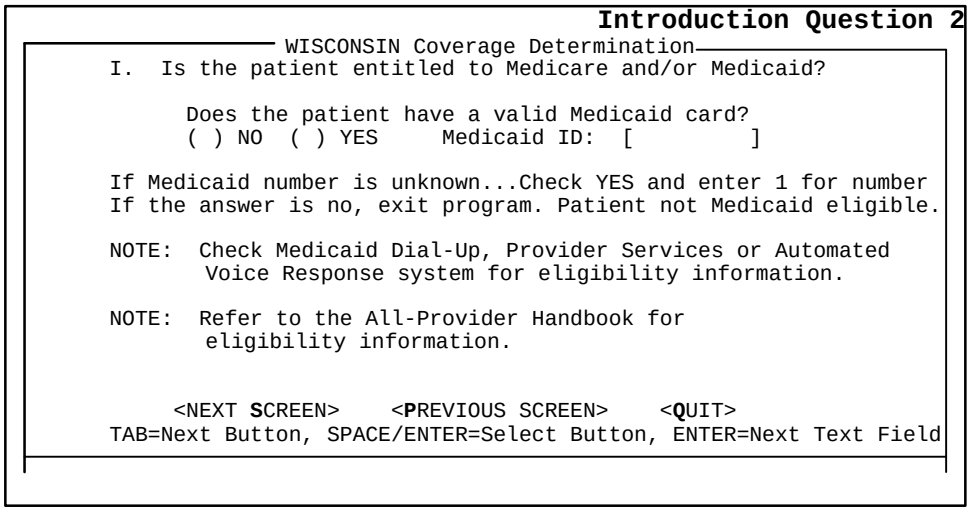
Click on both boxes or highlight a box and press enter to check if the patient is eligible for Part A and/or Part B coverage.

The commands at the bottom of the screen allow you to proceed to the next **S**creen or **Q**uit. The command to return to the P**R**evious screen is not functional for this screen since this is the first screen of the section.



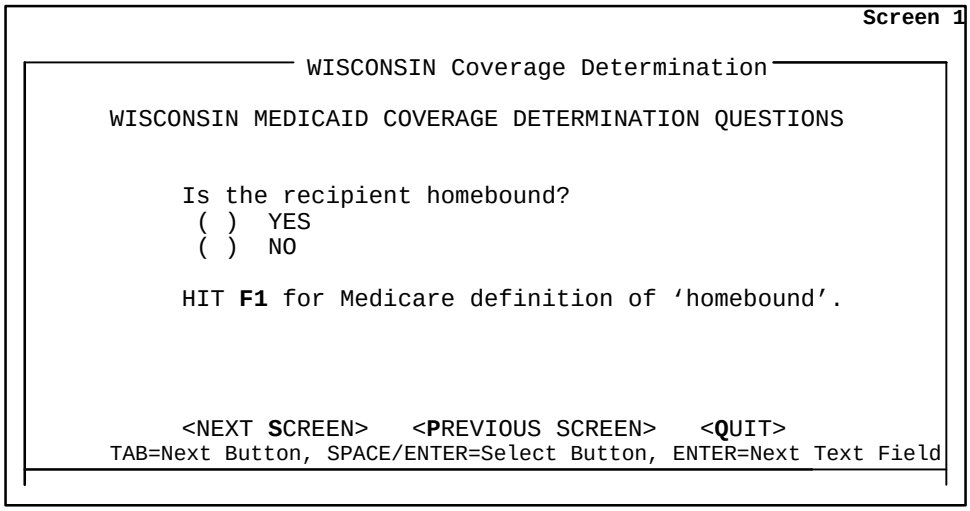
When Introduction Question 1 is completed, Press **S** to continue. The Introduction Question 2 screen appears, allowing you to gather Medicaid information.

This screen allows the user to confirm or enter the Medicaid ID number. If it is not known at this time, continue by entering a 1 for the ID, then pressing **S**.



Press **Q** to return to the Database Menu or Press **S** to continue on to the next screen. The next screen begins the series of questions used to determine if the patient's home care services qualify for Medicare coverage.

The question on screen 1 is to determine if the patient qualifies as "homebound." **Press F1** to review the Medicare definition of homebound. The definition pops up on a series of three screens. Press **Q**uit at any time to return to screen 1 (which contains the question, "Is the recipient homebound?"), or press **S** or **P** to move through the definition screens.



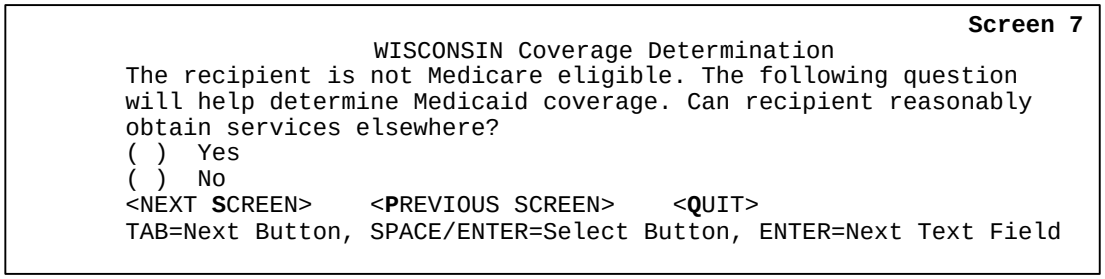
These three screens contain the definition of “homebound.” Press Q to return to screen 1.

```
                    Medicare Information                    Help for Screen 1

   Confined to the Home.

   A.  Patient Confined To The Home--In order for a patient
to be eligible to receive covered home health services under both
Part A and Part B, the law requires that a physician certify in all cases
that the patient is confined to his/her home.

An individual does not have to be bedridden to be considered as confined to
the home.  However, the condition of these patients should be such that
there exists a normal inability to leave home and, consequently, leaving
home would require a considerable and taxing effort.  If the patient does
in fact leave the home, the patient may nevertheless be considered
homebound if the absences from the home are infrequent or are for periods
of relatively short duration, or are attributable to the need to receive
medical treatment.

Definition continued on next screen...

Press QUIT to close definition...

        <NEXT SCREEN>    <PREVIOUS SCREEN>    <QUIT>
```

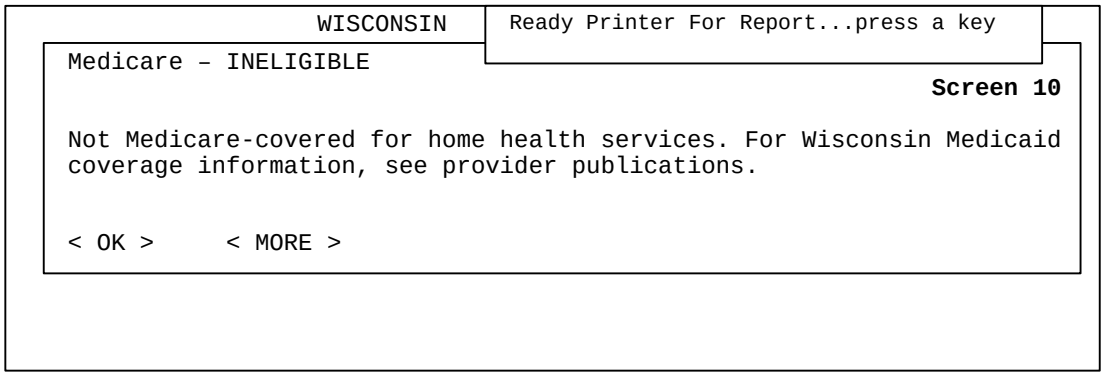
```
                                                            Help for Screen 1
                           Medicare Information

Medicare Homebound Definition - Page 2

Absences attributable to the need to receive medical treatment
include attendance at adult day care centers to receive medical care,
ongoing receipt of outpatient kidney dialysis, and the receipt of
outpatient chemotherapy or radiation therapy.  It is expected that in most
instances, absences from the home that occur will be for the purpose of
receiving medical treatment.

However, occasional absences from the home for nonmedical purposes (e.g.,
an occasional trip to the barber, a walk around the block, or a drive)
would not necessitate a finding that the patient is not homebound if the
absences are undertaken on an infrequent basis or are of relatively short
duration and do not indicate that the patient has the capacity to obtain
the health care provided outside rather than in the home.

Definition continued on next screen...

Press QUIT to close definition

     <NEXT SCREEN>     <PREVIOUS SCREEN>     <QUIT>
```

```
                                                            Help for Screen 1
                           Medicare Information

Medicare Homebound Definition - Page 3

Generally speaking, a patient will be considered to be homebound
if he or she has a condition due to an illness or injury that
restricts his or her ability to leave his or her place of residence except
with the aid of supportive devices such as crutches, canes, wheelchairs,
and walkers, the use of special transportation, or the assistance of
another person or if leaving home is medically contraindicated. See section
204.1 of the Medicare Home Health Agency Manual for more information.

Press QUIT to close definition...

        <NEXT SCREEN>    <PREVIOUS SCREEN>    <QUIT>
```

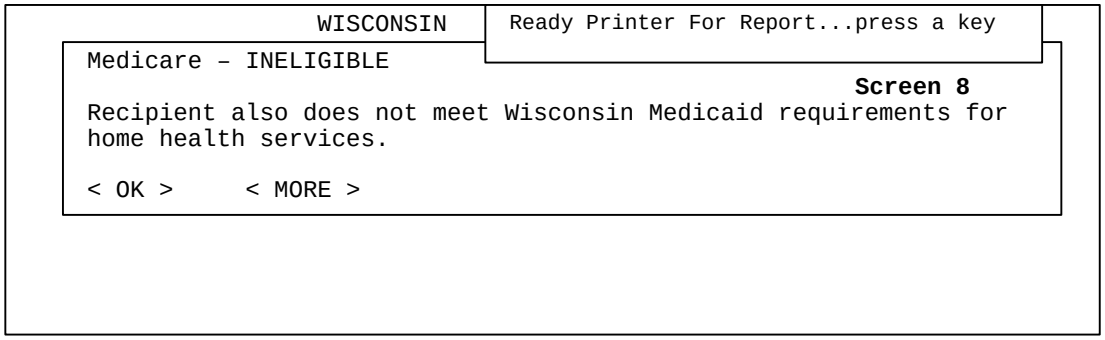
After closing the homebound definition, you return to screen 1. If the answer to the homebound question on screen 1 is NO, the patient is not eligible for Medicare home health services. A question on access to care pops up to assist you with Medicaid coverage determination.



A NO answer to screen 7 will display the following determination (screen 10). After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.



A YES answer to screen 7 will display the following determination (screen 8). After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.



When the homebound question on screen 1 is answered as YES, the following screen appears, asking if the patient requires physical or speech therapy, or has a continued need for occupational therapy.

```
                                                              Screen 2
                    WISCONSIN Coverage Determination

   Does recipient need Medicare-covered physical or speech therapy or
   have a continued need for occupational therapy?
               ( ) YES       ( ) NO

   Although a patient must be confined to the home to be eligible for
   covered home health services, some services cannot be provided at the
   patient's residence because equipment is required that cannot be made
   available there.

   If the services required by a patient involve the use of such
   equipment, the home health agency may make arrangements with a
   hospital, skilled nursing facility, or a rehabilitation center to
   provide these services on an outpatient basis.  However, even in these
   situations, for the services to be covered as home health services the
   patient must be considered confined to his or her home. To receive
   such outpatient services, a homebound patient will generally require
   the use of supportive devices, special transportation, or the
   assistance of another person to travel to the appropriate facility.

       <NEXT SCREEN>    <PREVIOUS SCREEN>    <QUIT>
   TAB=Next Button, SPACE/ENTER=Select Button, ENTER=Next Text Field
```

When YES for screen 2 is selected, screen 6 appears (see screen 6 on page 23). Answering the question on screen 6 will lead to a determination. After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.

When NO for screen 2 is selected, screen 3 appears (below).

```
                                                              Screen 3
                    WISCONSIN Coverage Determination


   Does recipient need Medicare-covered skilled nursing fewer than seven
   days per week or less than eight hours of each day for periods of 21
   days or less, with extension in exceptional circumstances when the need
   for additional care is finite and predictable? For example: multiple
   recert periods for recurrent instabilities or for long term care with
   progress being made (e.g., slowly healing wounds).
               ( )  YES     ( )  NO

   If the only reason for the skilled nursing services is medication set-
   up, prefilling insulin syringes, or venipuncture, the visit does not
   qualify for Medicare. Therefore, you should answer NO to this question.

   Hit F2 for Medicare Care of Wounds example.

       <NEXT SCREEN>     <PREVIOUS SCREEN>     <QUIT>
   TAB=Next Button, SPACE/ENTER=Select Button, ENTER=Next Text Field
```

Press the **F2** key to reference a definition of "Care of Wounds."

The following screen is the definition of “Care Of Wounds.” This is a one-screen definition. To return to the previous screen, select **Q**uit.

```
                                                          Help for Screen 3
                              Medicare Information

Care Of Wounds (including, but not limited to ulcers, burns, pressure
sores, open surgical sites, fistulas, tube sites and tumor erosion sites)
when the skills of a licensed nurse are needed to provide safely
and effectively the services necessary to treat the illness or
injury, is considered to be a skilled nursing service.  For skilled
nursing care to be reasonable and necessary to treat a wound, the
size, depth, nature of drainage (color, odor, consistency and quantity),
condition and appearance of the skin surrounding the wound must be
documented in the clinical findings so that an assessment of the need for
skilled nursing care can be made.  Coverage or denial of skilled nursing
visits for wound care may not be based solely on the stage classification
of the wound, but rather must be based on all of the documented clinical
findings.  Moreover, the plan of care must contain the specific
instruction for the treatment of the wound. See section 205.1 of the
Medicare Home Health Agency Manual for more information.

Press QUIT to close definition...

       <QUIT>
```

When YES for screen 3 is selected, screen 6 appears (see screen 6 on page 23). Answering the question on screen 6 will lead to a determination. After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.

Answering NO to screen 3 causes screen 4 to appear. Additional information about Vitamin B injections and catheter care is available by pressing **F3.**

```
                                                                Screen 4
                      WISCONSIN Coverage Determination


     Does recipient need skilled nursing fewer than seven days per week
     for long term care for any Medicare-covered services? For example:
     catheter changes, or vitamin B-12 or calcimar injections?
                  ( ) YES         ( ) NO

     If the only reason for the skilled care is medication set-up,
     prefilling insulin syringes, or venipuncture, the visit does not
     qualify for Medicare. Therefore, you should answer NO to this
     question.

     Hit F3 for Medicare vitamin B-12 and catheter care examples.

          <NEXT SCREEN>    <PREVIOUS SCREEN>    <QUIT>
     TAB=Next Button, SPACE/ENTER=Select Button, ENTER=Next Text Field
```

The following screen contains information about Vitamin B injections and catheter care. Press **Q**uit after reviewing the information.

```
                                                          Help for Screen 4
                              Medicare Information

   For a patient with pernicious anemia caused by a B-12 deficiency,
intramuscular or subcutaneous injection of vitamin B-12 at a dose from
100 to 1000 micrograms no more frequently than once monthly is the
accepted reasonable and necessary dosage schedule for maintenance
treatment.  More frequent injections would be appropriate in the initial
or acute phase of the disease until it has been determined through
laboratory tests that the patient can be sustained on a maintenance dose.

   Insertion and sterile irrigation and replacement of catheters, care of
suprapubic catheter, and, in selected patients, urethral catheters, are
considered to be skilled nursing services.  Where the catheter is
necessitated by a permanent or temporary loss of bladder control, skilled
nursing services are provided at a frequency appropriate to the type of
catheter in use would be considered reasonable and necessary. Absent
complications, Foley catheters generally require skilled care
approximately once every 30 days and silicone catheters generally require
skilled care once every 60-90 days and this frequency of service would be
considered reasonable and necessary.  However, where there are
complications that require more frequent skilled care related to the
catheter, such care would, with adequate documentation, be covered. See
section 205.1 of the Medicare Home Health Agency Manual for more
information.

Press QUIT to close definition...
    <QUIT>
```

When YES for screen 4 is selected, screen 6 appears (see screen 6 on page 23). Answering the question on screen 6 will lead to a determination. After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.

If you answered NO to screen 4, screen 5 appears with a question regarding the need for insulin injections.

```
                                                                 Screen 5
                      WISCONSIN Coverage Determination


  Is skilled nursing (up to and including several visits per day, seven days
  per week) needed long term for a recipient who is physically or mentally
  unable to self-administer insulin and there is no willing and able caregiver?
              ( ) YES
              ( )  NO
  If the only reason for the skilled nursing services is medication
  set-up, prefilling insulin syringes, or venipuncture, the visit
  does not qualify for Medicare. Therefore, you should answer NO to this
  question.



    Hit F4 for Medicare Insulin Injection example.


           <NEXT SCREEN>    <PREVIOUS SCREEN>    <QUIT>
    TAB=Next Button, SPACE/ENTER=Select Button, ENTER=Next Text Field
```

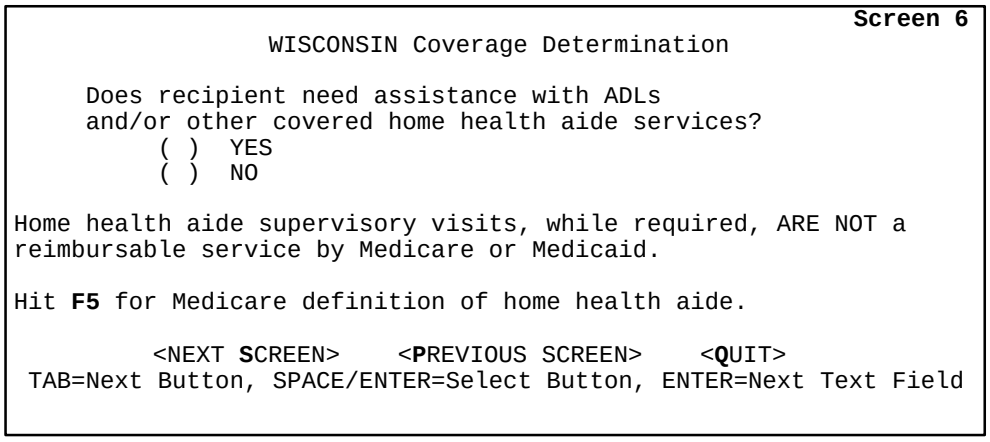
For assistance in answering the question on screen 5, press **F4** for additional information. A single help screen appears. Press **Q**uit after reviewing.

```
                                                    Help for Screen 5
                          Medicare Information

Insulin is customarily self-injected by patients or injected by
their families.  However, where a patient is either physically or
mentally unable to self-inject insulin and there is no other person
able and willing to inject the patient, the injections would be
considered a reasonable and necessary skilled nursing service.

For example, a patient who requires an injection of insulin once per
day for treatment of diabetes mellitus, also has multiple sclerosis
with loss of muscle control in the arms and hands, occasional tremors,
and vision loss that causes inability to fill syringes or self-inject
insulin.  If there is no able and willing caregiver to inject the
insulin, skilled nursing care would be reasonable and necessary for
the injection of the insulin. See section 205.1 of the Medicare Home
Health Agency Manual for more information.

Press QUIT to close definition...
   < QUIT >
```

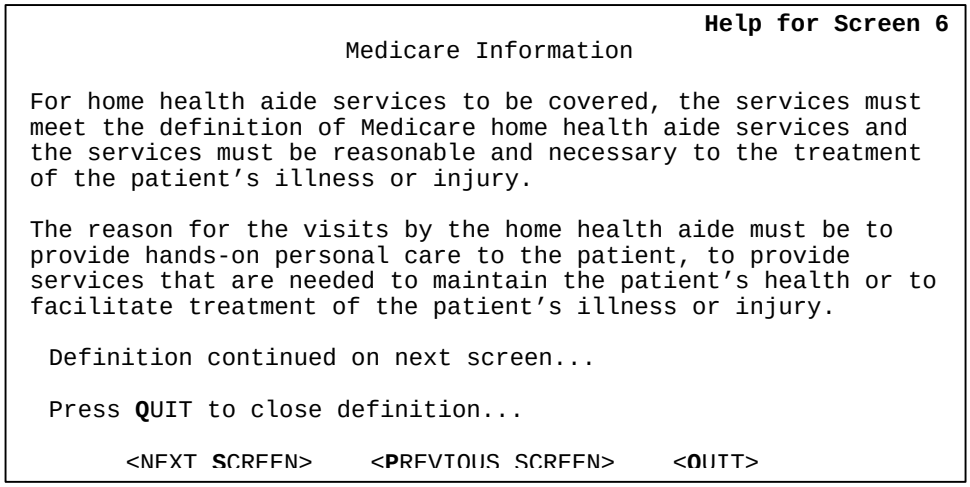
A NO answer to screen 5 will display the following determination (screen 9). After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.

```
                    WISCONSIN        Ready Printer For Report...press a key


                                                          Screen 9

 Medicare - INELIGIBLE

 Not Medicare-covered for home health services. For Wisconsin
 Medicaid coverage information, see provider publications.


      <NEXT SCREEN>      <PREVIOUS SCREEN>      <QUIT>
   TAB=Next Button, SPACE/ENTER=Select Button, ENTER=Next Text Field
```

If any of the questions on screens 2, 3, 4 or 5 are answered YES, the following prompt regarding the need for assistance with activities of daily living (ADL) pops up.



For assistance in answering the ADL question, press **F5** for additional information. A three-screen definition appears. Press **Q**uit after reviewing.



Help for Screen 6

WISCONSIN Coverage Determination

The physician's order should indicate the frequency of the home health aide services required by the patient. These services may include but are not limited to:

a. Personal Care – Personal care means: Bathing, dressing, grooming, caring for hair, nail, and oral hygiene that are needed to facilitate treatment or prevent deterioration of the patient's health; changing the bed linens of an incontinent patient; shaving; deodorant application; skin care with lotions and/or powder; foot care; ear care; feeding; assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition); routine catheter care; routine colostomy care; assistance with ambulation; changing position in bed; and assistance with transfers.

Definition continued on next screen...

Press **Q**UIT to close definition...

<NEXT **S**CREEN> <**P**REVIOUS SCREEN> <**Q**UIT>

Help for Screen 6

WISCONSIN Coverage Determination

b. Simple dressing changes that do not require the skills of a licensed nurse.

c. Assistance with medications that are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively.

d. Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services.

Definition continued on next screen...

Press **Q**UIT to close definition...

<NEXT **S**CREEN> <**P**REVIOUS SCREEN> <**Q**UIT>

Help for Screen 6

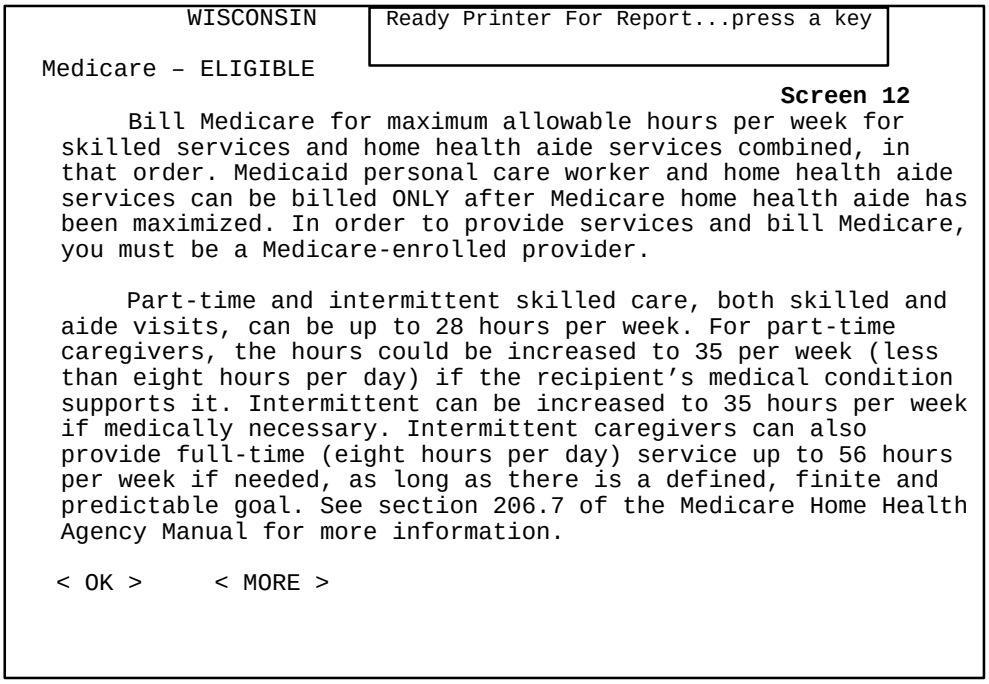
WISCONSIN Coverage Determination

d. Routine care of prosthetic and orthotic devices. When a home health aide visits a patient to provide a health-related service as discussed above, the home health aide may also perform some incidental services that do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, and shopping). However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health-related services, but rather are necessary household tasks that must be performed by anyone to maintain a home. See section 206.2 of the Medicare Home Health Agency Manual for more information.

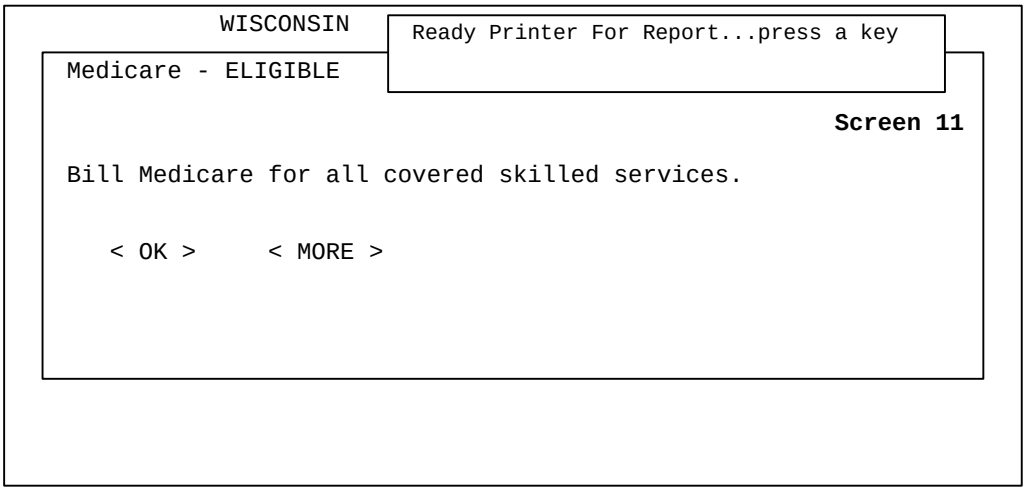
Press **Q**UIT to close definition...

<NEXT **S**CREEN> <**P**REVIOUS SCREEN> <**Q**UIT>

A YES answer to screen 6 will display the following determination (screen 12). After reading the determination, press enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.

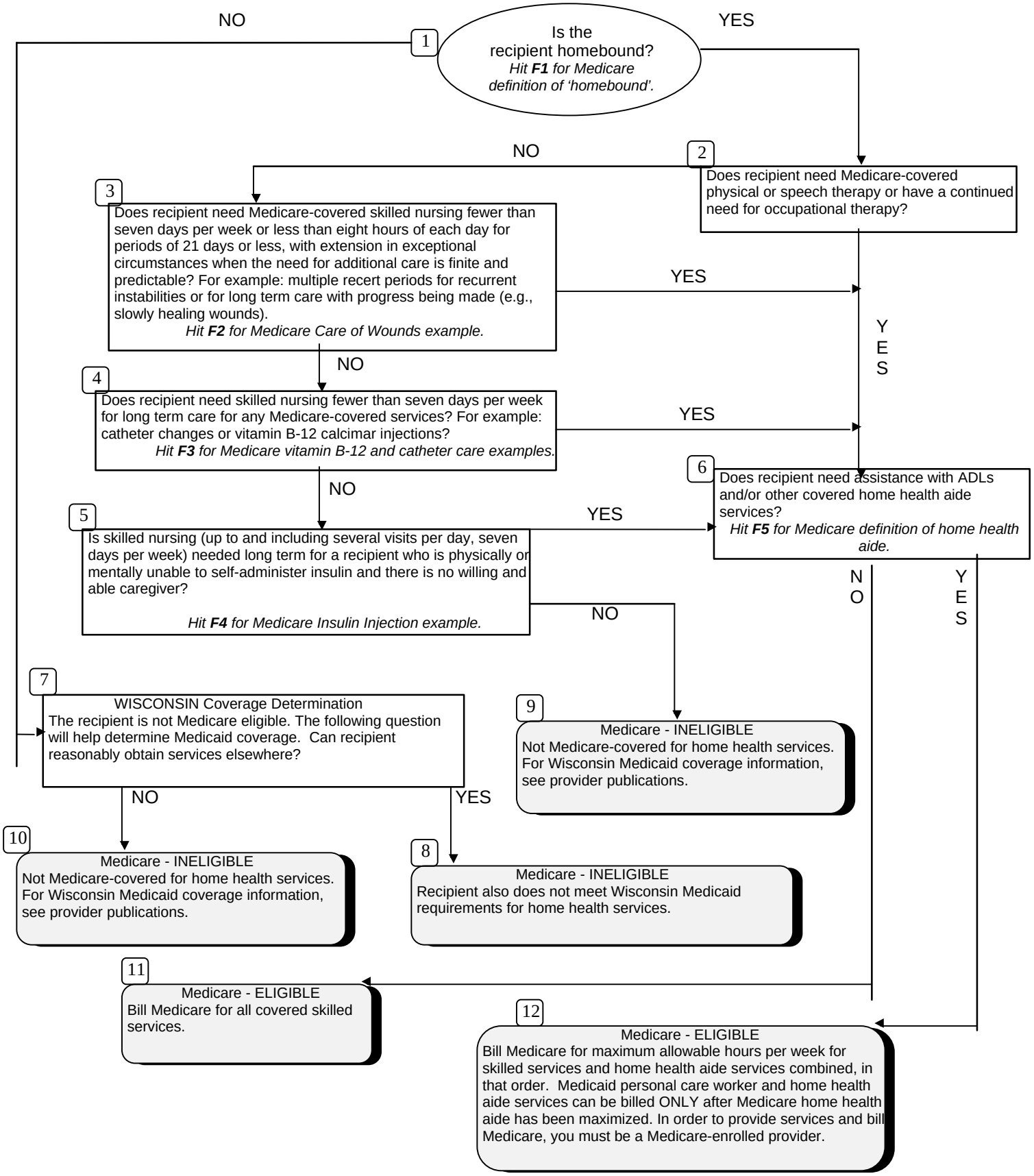


A NO answer to screen 6 will display the following determination (screen 11). After reading the determination, press Enter. A one-page report stating this determination for the specified recipient will print automatically and you will be returned to the Main Menu.



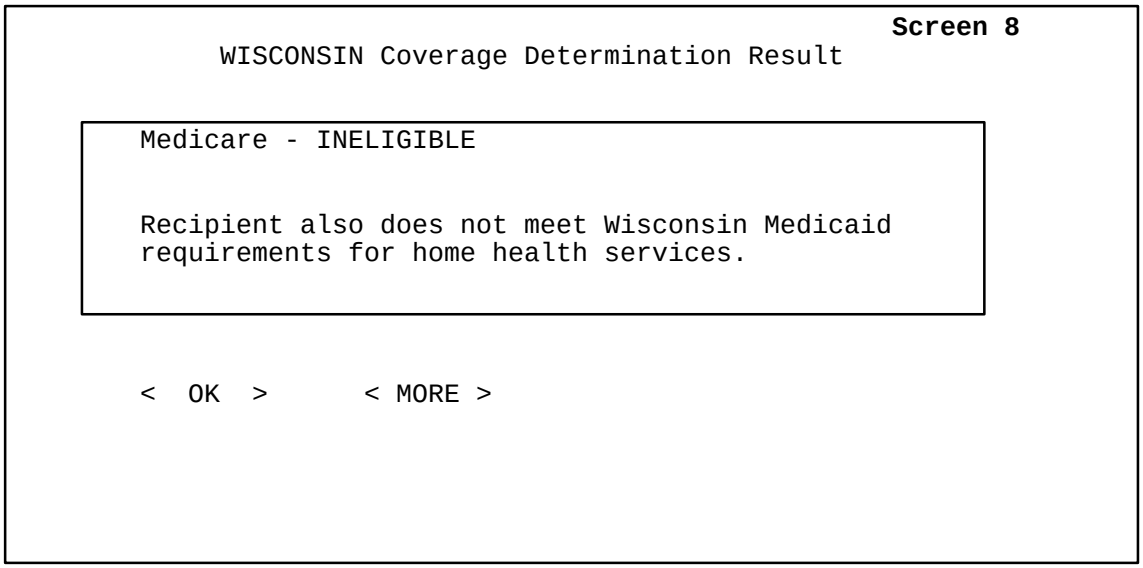
All determination screens can be found in Appendix B.

Wisconsin Medicaid Coverage Flowchart — Appendix A

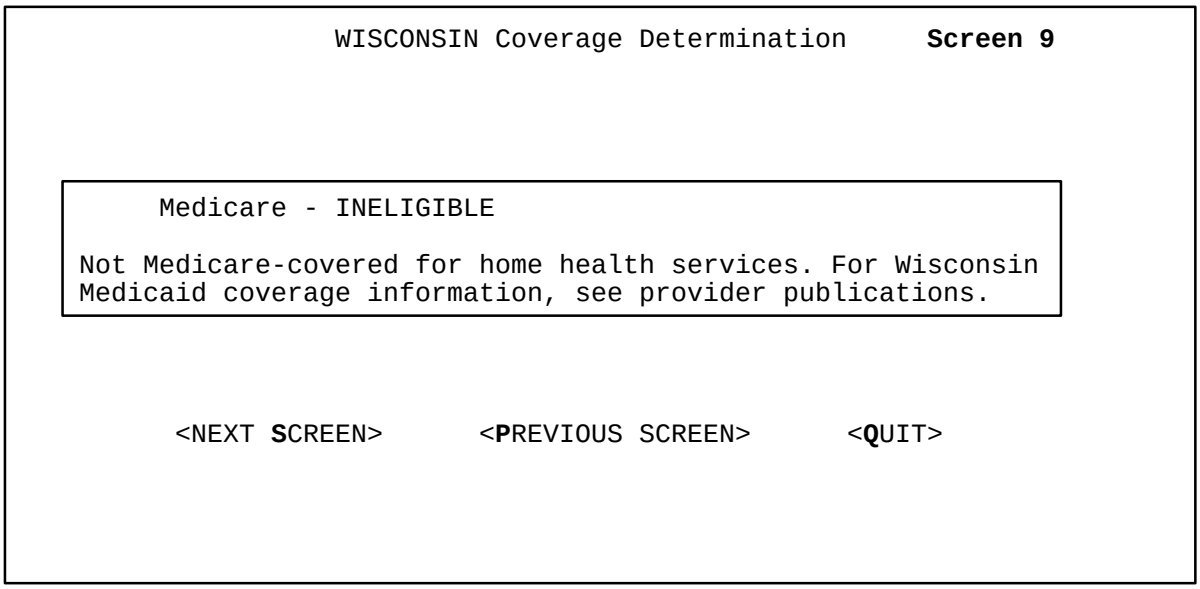


DETERMINATION SCREENS

8 Your answers indicate the recipient is ineligible for Medicare home health services.



9 Your answers indicate the recipient is ineligible for Medicare home health services.



DETERMINATION SCREENS cont.

10 Your answers indicate the recipient is ineligible for Medicare home health services.

```
                  WISCONSIN Coverage Determination Result   Screen 10

   Medicare - INELIGIBLE

   Not Medicare-covered for home health services. For
   Wisconsin Medicaid coverage information, see
   provider publications.



<  OK  >      < MORE >
```

11 Your answers indicate the recipient is eligible for Medicare home health services. Bill Medicare for all covered skilled services.

```
                  WISCONSIN Coverage Determination Result   Screen 11

     Medicare - ELIGIBLE
     Bill Medicare for all covered skilled services.



     <  OK  >      < MORE >
```

DETERMINATION SCREENS cont.

12 Your answers indicate the recipient is eligible for Medicare home health services. Bill Medicare up to the maximum allowable hours per week.

WISCONSIN Coverage Determination Result **Screen 12**

Medicare - ELIGIBLE

Bill Medicare for maximum allowable hours per week for skilled services and home health aide services combined, in that order. Medicaid personal care worker and home health aide services can be billed ONLY after Medicare home health aide has been maximized. In order to provide services and bill Medicare, you must be a Medicare-enrolled provider.

Part-time and intermittent skilled care, both skilled and aide visits, can be up to 28 hours per week. For part-time caregivers, the hours could be increased to 35 per week (less than eight hours per day) if the recipient's medical condition supports it. Intermittent can be increased to 35 hours per week if medically necessary. Intermittent caregivers can also provide full-time (eight hours per day) service up to 56 hours per week if needed, as long as there is a defined, finite and predictable goal. See section 206.7 of the Medicare Home Health Agency Manual for more information.

< OK > < MORE >

Determination Reason Codes

Wisconsin coverage determination list - reason and qualifier code key codes appear on determination screens

CODE	DESCRIPTION
HHNC	Recipient does not meet Wisconsin Medicaid requirements for home health services.
NOMCS	Not Medicare-covered for home health services. For Wisconsin Medicaid coverage information, see provider publications.
PABIL	Not Medicare-covered for home health services. For Wisconsin Medicaid coverage information, see provider publications.
HBALL	Bill Medicare for all covered skilled services.
HB35	Bill Medicare for maximum allowable hours per week for skilled services and home health aide combined, in that order. Medicaid personal care worker and home health aide services can be billed ONLY after Medicare home health aide has been maximized. In order to provide services and bill Medicare, you must be a Medicare-enrolled provider.

Error Codes

These error codes will appear if an error is made while running the software.

CODE	DESCRIPTION
MIOO1	Medicare eligibility not met.
DIOO1	Patient is not eligible for Medicaid.
MQOO1	Program terminated early, but Medicare is valid up to stopping point.
DQOO1	Program terminated early, but Medicaid is valid up to stopping point.