wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Ambulance Providers
HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for ambulance services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for ambulance services, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising Medicaid PA request forms and instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for ambulance services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are *not* policy or coverage related (e.g., PA requirements, documentation requirements), but include:

- Adopting nationally recognized procedure codes and place of service (POS) codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising PA request forms and instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes, revised paper claim instructions, or revised PA forms and instructions prior to implementation dates may result in claim denials and returned PA requests. Specific implementation dates will be published in a future *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for ambulance services.

Allowable procedure codes

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local procedure codes for ambulance services. Refer to Attachment 1 of this *Update* for a procedure code conversion

chart. Providers will be required to use the appropriate procedure code that describes the service performed.

Refer to Attachment 2 for a list of Healthcare Common Procedure Coding System (HCPCS) codes for disposable medical supplies (DMS) and services that may or may not be billed separately for ambulance services. For both DMS and ambulance services with no listed national HCPCS procedure codes, providers may use HCPCS procedure code A0999 (Unlisted ambulance service).

Modifiers

Providers will be required to use nationally recognized HCPCS modifiers in place of the local modifiers currently used by Wisconsin Medicaid. Modifier changes and additions for ambulance services are as follows:

- National modifiers with state-defined descriptions for ambulance services will replace the local trip modifiers "11"-"20." Wisconsin Medicaid ambulance providers will be required to use national modifiers "U1"-"U6" to indicate the trip number. *All* procedure codes will require a trip modifier. Use trip modifiers on claims but not on PA requests.
- Providers will be required to use modifier "GM" (Multiple patients on one ambulance trip) when transporting two or more Medicaid recipients on the same trip. Use the "GM" modifier on claims but not on PA requests.
- Providers will be required to use the following ambulance origin and destination modifiers: "D," "E," "G," "H," "I," "J," "N," "P," "R," "S," and "X." These single-letter modifiers are used in combination on the claim form to indicate the origin and destination of the ambulance trip. The first letter indicates the transport's place of origin; the second letter indicates the destination. Use origin and destination modifiers on claims but not on PA requests.

Refer to Attachment 3 for a listing of national HCPCS modifiers with their descriptions for ambulance services.

All procedure codes will require a trip modifier.

Type of service codes

Type of service codes will no longer be required on Medicaid claims and PA requests.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Providers will use the appropriate POS code designating the destination of the transport. Refer to Attachment 4 for a list of allowable POS codes for ambulance services.

Ambulance waiting time in half-hour increments

Local code A0060 (Miscellaneous services, waiting time) will be replaced with code A0420 (Ambulance waiting time [ALS or BLS], one-half [1/2] hour increments). Waiting time units will be based on half-hour increments (e.g., 1.0 unit = Half-hour to one hour of waiting time). Wisconsin Medicaid does not separately cover waiting time if less than a half-hour.

Refer to Attachment 5 for a table listing the rounding guidelines for ambulance waiting time.

Diagnosis codes

Local diagnosis codes "V919" (Emergency transport) and "V920" (Nonemergency transport) will be eliminated. Ambulance providers may use the *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code V82.9 (Unspecified condition) if a valid diagnosis is unknown.

Coverage for ambulance services

Medicaid coverage and documentation requirements for ambulance providers will remain unchanged. Refer to the Ambulance Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified ambulance providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 6 for the revised instructions. Attachments 7 and 8 are sample claims for ambulance services that reflect the changes to the billing instructions.

A physician prescription must be included with each PA request.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the CMS 1500 claim form instructions

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Other insurance indicators were revised (Element 9).
- Medicare disclaimer codes were revised (Element 11).
- Place of service codes were revised (Element 24B).
- Type of service codes will no longer be required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- Spenddown amount will no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.
- Wisconsin Medicaid will no longer accept mother/baby claims. Refer to the June 2003 *Update* (2003-29), titled "Wisconsin Medicaid no longer reimburses claims for newborns under the mother's identification number," for more information.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, ambulance providers will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03. Instructions for completion of this revised form are located in Attachment 9. A sample PA/RF is in Attachment 10.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Requested start date field will be added (Element 14).
- Place of service codes were revised (Element 18).
- Type of service codes will no longer be required.

Prior authorization attachments

Ambulance providers should use the Prior Authorization Physician Attachment (PA/PA), HCF 11016, dated 01/03, for services that require PA. Refer to Attachment 11 for a copy of the completion instructions for the PA/PA. Attachment 12 is a copy of the PA/PA for providers to photocopy.

Note: A physician prescription must be included with each PA request.

Obtaining prior authorization request forms

The PA/PA is available in a fillable Portable Document Format (PDF) from the forms page

of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it.) To access the PA/PA and other Medicaid forms, follow these instructions:

1. Go to *www.dhfs.state.wi.us/medicaid/*.
2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader®* and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/PA or PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the HCF number of the form (if applicable) and send the request to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- a*spe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

ATTACHMENT 1
Procedure code conversion chart for ambulance services

The following table lists the nationally recognized procedure codes that providers will be required to use when submitting claims for ambulance services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description**	**Replaced by HCPCS[1] procedure code**	**HCPCS procedure code description**	**Multiple carry modifier**
W9074	Miscellaneous services, isolette, up to three hours	**A0225**	Ambulance service, neonatal transport, base rate, emergency transport, one way	
W9075	Miscellaneous services, isolette, over three hours			
A0215	Miscellaneous services, disposable items	**A0382***	BLS[2] routine disposable supplies	
		A0384*	BLS specialized service disposable supplies; defibrillation (used by ALS[3] ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	
		A0392*	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)	
		A0394*	ALS specialized service disposable supplies; IV drug therapy	
		A0396*	ALS specialized service disposable supplies; esophageal intubation	
		A0398*	ALS routine disposable supplies	
		A0999*[4]	Unlisted ambulance service	
A0060	Miscellaneous services, waiting time	**A0420**	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	
A0070	Miscellaneous services, oxygen	**A0422***	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	
W9078	Miscellaneous services, third attendant	**A0424**	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged)	

* Refer to Attachment 2 of this *Update* for a list of disposable medical supplies (DMS) that may be billed for each procedure code.

1 HCPCS = Healthcare Common Procedure Coding System.

2 Wisconsin Medicaid assigns Basic Life Support (BLS) status to all land ambulance providers with a Department of Health and Family Services (DHFS) ambulance service provider license at the basic level.

3 Wisconsin Medicaid assigns Advanced Life Support (ALS) status to all land ambulance providers with a DHFS ambulance service provider license at the intermediate or paramedic level.

4 This code may be used for both DMS and ambulance services if a more specific code is unavailable.

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description**	**Replaced by HCPCS[1] procedure code**	**HCPCS procedure code description**	**Multiple carry modifier**
A0020	Ambulance emergency mileage	**A0425**	Ground mileage, per statute mile	
W9072	Ambulance nonemergency mileage			
W9082	Ambulance multiple carry mileage, two recipients	**A0425**	Ground mileage, per statute mile	**GM**
W9083	Ambulance multiple carry mileage, three or more recipients			
W9081	Ambulance multiple carry base rate	**A0426**	Ambulance service, advance life support, non-emergency transport, level 1 (ALS 1)	**GM**
		A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 — emergency)	**GM**
		A0428	Ambulance service, basic life support, non-emergency transport (BLS)	**GM**
		A0429	Ambulance service, basic life support, emergency transport (BLS — emergency)	**GM**
		A0433	Advance life support, level 2 (ALS 2)	**GM**
		A0434	Specialty care transport (SCT)	**GM**
A0150	Ambulance nonemergency base rate	**A0426**	Ambulance service, advance life support, non-emergency transport, level 1 (ALS 1)	
		A0428	Ambulance service, basic life support, non-emergency transport (BLS)	
A0010	Ambulance emergency base rate	**A0427**	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 — emergency)	
		A0429	Ambulance service, basic life support, emergency transport (BLS — emergency)	
		A0433	Advance life support, level 2 (ALS 2)	
		A0434	Specialty care transport (SCT)	
W9060	Air ambulance, emergency base rate	**A0430**	Ambulance service, conventional air services, transport, one way (fixed wing)	
W9062	Air ambulance, nonemergency base rate	**A0431**	Ambulance service, conventional air services, transport, one way (rotary wing)	
W9061	Air ambulance, emergency mileage	**A0435**	Fixed wing air mileage, per statute mile	
W9063	Air ambulance, nonemergency mileage	**A0436**	Rotary wing air mileage, per statute mile	
W9051	Miscellaneous services, ambulance first aid at the scene	**T2006**	Ambulance response and treatment, no transport	
A0050	Water ambulance, emergency rate	No national codes have been assigned. Providers should use the land ambulance procedure code (with modifiers, if applicable) that best describes the service provided.		
W9050	Water ambulance, nonemergency rate			

[1] Healthcare Common Procedure Coding System.

ATTACHMENT 2
Ambulance disposable medical supplies and services

The following tables list the disposable medical supplies (DMS) and services that are included in the base rate for ambulance services and for supplies and services that may or may not be separately reimbursable. For DMS and services included in the base rate and codes A0382, A0384, A0392, A0396, A0398, A0422, and A0999, providers should bill only one unit of service per transport. For code A0394, providers may bill more than one unit of service per transport.

Included in ambulance base rate — Do not bill these supplies and services separately

The following DMS and services are included in the reimbursement for the ambulance base rate:

- Additional time — EMT.*
- Air splint.
- Alcohol preps.
- Alcohol.
- Ambulance bag, nondisposable.
- Application of equipment.
- Backboards.
- Blood draw for chemostrip.
- Blood pressure cuff.
- Blood pressure monitoring.
- Blood sample draw.
- Blood tubes, green, red, purple.
- Canister, nondisposable.
- Cassette tape.
- Cervical collar, nondisposable.
- Cervical Immobilization Systems (CIDS).
- Chair stretcher.
- Charges for reusable devices and equipment.
- Charges for vehicle sterilization.**
- Chemstrips/Dextrose Stix.
- Cloth.
- Code blue.
- Cot cover.
- Counter shock automatic.
- CPR.
- CPR/CPR board.
- Defibrillator monitor.
- Defibrillator, inverter.
- Demand valve resuscitator.
- Disposable face mask, not an oxygen mask.
- Dopplers.
- Drugs used in transit or for starting IV solutions.
- Egg crate mattress.
- EKG monitoring for infection control.
- Geriatric chairs.
- Gloves, disposable or sterile.
- Glucose stix.
- Glucometer supplies.
- Glucometer.
- Glucose monitoring.
- Goggles.
- Gowns, including disposable.
- Graph paper.
- Hazardous materials collection bags.
- Heart monitor.
- Infection control kit.
- Infusion pump.
- Inhalant.
- Intravenous infusion.
- Intubation.
- Isolation kits.
- Intermediate skills, I-Skills, D-Skills.
- IV pump.
- IV therapy.
- K-Y jelly.
- Kendrick Extrication Device (KED).
- Lancets.
- Laryngoscope blades, nondisposable.
- Linens.
- Loading assist.
- Long board.
- Major and minor bandaging.
- Mast trousers.
- Monitoring cassette.
- Needles.
- Nose clip.
- Para-med scissors.
- Peak flow meter.
- Perfusion monitoring.
- Pillow/pillowcases.
- Probe cover, thermoscan.
- Propaq monitor.
- Protective clothing.
- Pulmonary resuscitation.
- Pulse oximetry.
- Razor.
- Recording tape.
- Resuscitator, equipment charge.
- Sand bags.
- Scoop stretcher.
- Sharps container.
- Sheets.
- Splints, nondisposable.
- Stair chair.
- Straps.
- Stretcher.
- Suction.
- Surgical masks.
- Syringes.
- Tape.
- Telemetry.
- Temperature strip.
- Thermometer.
- Thermoscan.
- Towel.
- Traction splints bare treatment.
- Ventilator.
- Vita trac.
- Voice tape.
- Washcloth.

* Includes additional charges for services provided during nights, weekends, or holidays.

** Includes charges for carrying a recipient with a contagious disease.

A0382 or A0398 — Bill only one unit of service per transport

The following DMS are included in the reimbursement when billing procedure codes A0382 (BLS routine disposable supplies) or A0398 (ALS routine disposable supplies):

- Albuterol dispenser.
- Bandage/cravat.
- Bedpan, disposable.
- Bite stix.
- Blankets, disposable.
- Blood pressure cuff, disposable.
- Bloodstopper dressing.
- Bulb aspirator.
- Bulb aspirator tip.
- Burn sheets.
- Burn wraps.
- Canister, disposable.
- Cervical collar, disposable.
- Chux.
- CO_2 detector.
- Cold pack.
- Convenience bag.
- Disposable pads.
- Disposable V-block.
- Dressing.
- ECG electrodes.
- Emesis bag.
- Emesis basin.
- Fracture pan.
- Gauze.
- Glucose.
- Glucose gel.
- Glucose instant.
- Glucose tube.
- Head bed spine immobilizer, disposable.
- Head immobilizer, disposable.
- Head on system.
- Heart monitor pads.
- Hot pack.
- Insta glucose.
- Jamshidi aspiration needle.
- Kerlix dressing.
- Lancer tip.
- Portex tip.
- Proventil dispenser.
- Slings, disposable.
- Small trauma dressings.
- Sodium chloride, non-IV solution.
- Splints, disposable.
- Sterile saline, non-IV.
- Sterile water, non-IV.
- Straps head/chin, disposable.
- Suction cartridge.
- Suction canister, disposable.
- Suction catheters.
- Suction tip.
- Suction tip and tubing.
- Suction tubing.
- Trauma dressing.
- Trauma pack.
- Triangle bandage.
- Tube of glucose.
- Tube, salem sump.
- Underpad.
- Urinal.
- Vaseline gauze.
- Veni dress.
- V-vac cartridge.
- Whistle tip, suction tip.
- Yankhauer catheter.
- Yankhauer tip.
- Yankhauer tip with tubing.
- Yankhauer tubing.

A0384 or A0392 — Bill only one unit of service per transport

The following DMS are included in the reimbursement when billing procedure codes A0384 (BLS specialized service disposable supplies; defibrillation) or A0392 (ALS specialized service disposable supplies; defibrillation):

- Defibrillator electrodes.
- Defibrillator pads.
- Defibrillator supplies.
- Defibrillator pads.
- Fast patch.

A0394 — May be billed for more than one unit of service per transport

The following DMS are included in the reimbursement when billing procedure code A0394 (ALS specialized service disposable supplies; IV drug therapy):

- Angiocath needle.
- Angio set.
- Backcheck venoset.
- Backcheck vent.
- Catheter, IV.
- Dial a flow or IV flow.
- Disposable arm pad.
- Disposable arm boards.
- Extension.
- Extension set, tubing.
- IV administration sets.
- IV antiseptic wipes.
- IV armboard.
- IV blood tubing.
- IV cassette.
- IV cath.
- IV cath protector.
- IV equipment.
- IV medical tubing or IV tubing.
- IV micro tubing.
- IV prep pack.
- IV pump ext set.
- IV pump ext tubing set.
- IV select 3 tubing.
- IV start pack.
- IV supplies.
- IV tape.
- IV three-way stop-cock extension.
- IV trauma set.
- IV Y-site tubing.
- IV 2x2.
- Luer lock adapter.
- Pump tubing IV supplies.
- Regular drip set, tubing.
- Tourniquet.
- Twin site extension.
- Twin ext set.
- Venaguard cath.
- Vena guard.
- Y-site tubing.

A0396 — Bill only one unit of service per transport

The following DMS are included in the reimbursement when billing procedure code A0396 (ALS specialized service disposable supplies; esophageal intubation):

- Adult stylette, disposable.
- Airway.
- Airway valve.
- Catheter guide for airways.
- Combi tube.
- Endotracheal tube guides.
- Endotracheal tubes, ET tube.
- Esophageal gastric tube airway (EGTA).
- EGTA mask.
- TGTA tube.
- Esophageal obturator airway (EOA).
- EOA mask.
- EOA tube.
- Intubation tubing.
- Laryngoscope blades, disposable.
- Pharyngeal tracheal lumen (PTL) airway.
- PTL airway.
- Revive easy airway, PTL.
- Secure easy ET holder.
- Stylette.

A0422 — Bill only one unit of service per transport

The following DMS and services are included in the reimbursement when billing procedure code A0422 (Ambulance [ALS or BLS] oxygen and oxygen supplies, life sustaining situation):

- Autovent with bag mask.
- Ambu disposable resuscitator.
- Ambu SPUR.
- Bag easy resuscitator.
- Bag valve, one-way valve.
- Blob seal, seal easy mask.
- Cannula, nasal cannula.
- Humidified oxygen.
- Humidifiers.
- LSP disposable resuscitator.
- Mouth to mask resuscitation.
- Mouth to mask valve.
- Nasal airway, disposable.
- Nasal cannula.
- Nasopharyngeal.
- Nebulizer dispenser.
- Nebulizer setup.
- Nebulizer.
- Non-rebreathing masks.
- Non- or partial-rebreather.
- Oxygen delivery.
- Oxygen masks.
- Oxygen mask with tubing.
- One-way valve.
- Oral pharyngeal.
- Oxygen tubing.
- Oxygen connection tube.
- PEEP Valve.
- Pocket mask.
- Pulse oximeter sensor, disposable.
- Rebreathing mask.
- Resuscitation kit.
- Resuscitator mask.
- Simple mask.
- Tracheostomy mask or collar.
- Venturi mask.
- WPR.

A0999* — Bill only one unit of service per transport

The following disposable supplies are included in the reimbursement when billing procedure code A0999 (Unlisted ambulance service):

- Burn blanket.
- IV nitro tubing.
- Pacing pads/pacing electrodes.
- Pressure infuser, disposable.
- Ob-Gyn supplies or kit.
- OB/3 stage kit.
- Zoll pacing pad.

* Providers should use procedure code A0999 for any DMS or service not listed in this attachment.

ATTACHMENT 3
National modifiers for ambulance services

The following tables list the nationally recognized modifiers that providers will be required to use when submitting claims for ambulance services. Use modifiers on claims but not on prior authorization requests. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Multiple carry modifier	Description
GM	Multiple patients on one ambulance trip

Trip modifiers	Description
U1	First or only trip
U2	Second trip
U3	Third trip
U4	Fourth trip
U5	Fifth trip
U6	Sixth trip

Origin and destination modifiers*	Description
D	Diagnostic or therapeutic site other than "P" or "H"
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad between types of ambulance)
J	Nonhospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO nonhospital facility, clinic)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office en route to the hospital (includes HMO nonhospital facility, clinic) *Note:* Modifier "X" can only be used as a designation code in the second position of a modifier.

* These single-letter modifiers are used in combination on the claim form to indicate the origin and destination of the ambulance trip. The first letter indicates the transport's place of origin; the second letter indicates the destination.

ATTACHMENT 4
Place of service codes for ambulance services

The following table lists the nationally recognized place of service (POS) codes that providers will be required to use when submitting claims and prior authorization requests for ambulance services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

POS code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance — Land
42	Ambulance — Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 5
Rounding guidelines for waiting time

With the implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), ambulance waiting time units will be based on half-hour increments (e.g., 1.0 unit = 1/2 hour to one hour of waiting time). Wisconsin Medicaid does not separately cover waiting time if less than a half-hour. The table below lists the rounding guidelines for waiting time.

Units	Time increments
1.0	½ hour to 1 hour
2.0	1 to 1 ½ hours
3.0	1 ½ to 2 hours
4.0	2 to 2 ½ hours
5.0	2 ½ to 3 hours
6.0	3 to 3 ½ hours
7.0	3 ½ to 4 hours
8.0	4 to 4 ½ hours
9.0	4 ½ to 5 hours
10.0	5 to 5 ½ hours
11.0	5 ½ to 6 hours

ATTACHMENT 6
CMS 1500 claim form instructions for ambulance services
(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "A" in the Medicaid check box for the service billed. Claims submitted without this indicator will be denied.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the 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 whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

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

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance 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 in part or in full by commercial health insurance or commercial HMO. 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 commercial health insurance or commercial HMO 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.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, 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. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the 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 that 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.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

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

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost ("MCC") or Medicare + Choice ("MPC"), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- 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 previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
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 dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *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 the provider was not certified 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 the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *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, or the service 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 is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *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 in this circumstance (e.g., 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 in this circumstance (e.g., 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 (required, if applicable)

Required for nonemergency services. 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)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (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 V82.9 (Unspecified condition) if a valid diagnosis is unknown. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each service 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 enter subsequent DOS in the "To" field by listing **only** the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

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

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

Element 24B — Place of Service

Enter the appropriate two-digit POS code designating the destination of the transport.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG

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

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

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

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

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 (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. Minimum requirement is the provider's name, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 7

Sample CMS 1500 claim form for emergency transport

(One round trip with nonemergency return destination)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [A] (Medicaid #) 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 St

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

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

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

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

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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 _____

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. V82.9 3. 2. 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 11 04 03		23		A0427	U1 NH	1	XX XX	1.0		E		
2 11 04 03		23		A0425	U1 NH	1	XX XX	9.5		E		
3 11 04 03		23		A0420	U1 HN	1	XX XX	1.0				
4 11 04 03		31		A0425	U2 HN	1	XX XX	9.5				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

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.)

I.M. Ordering 11/30/03

SIGNED DATE

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 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 8

Sample CMS 1500 claim form for emergency transport with multiple patients on board

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | 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 ☐ F ☒

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

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

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

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: | STATE:

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

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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 _____

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 MM DD YY FROM 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 MM DD YY FROM 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. 410.9
2.
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	11 04 03		23		A0427	U1 GM SH	1	XX XX	1.0		E		
2	11 04 03		23		A0425	U1 GM SH	1	XX XX	15.0		E		
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO. 1234JED

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.)

I.M. Billing 11/30/03

SIGNED DATE

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 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 9
Prior Authorization Request Form (PA/RF) Completion Instructions for ambulance services

(For prior authorization submitted after HIPAA implementation)

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

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

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

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization Physician Attachment (PA/PA) and physician prescription by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type 999 (Other). Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the 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 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description
Enter the *International Classification of Diseases, Ninth Edition, Clinical Modification* diagnosis code V82.9 (Unspecified condition) if a valid diagnosis is unknown.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description (not required)

Element 14 — Requested Start Date (not required)

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure/item requested.

Element 17 — Modifiers (not required)

Element 18 — POS
Enter the appropriate two-digit place of service code designating the destination of the transport.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 20 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 21 — Charge

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charge

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 10
Sample Prior Authorization Request Form (PA/RF) for ambulance services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) completion instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **10 W. Williams** **Anytown, WI 55555**	**(555) 123-4567** 4. Billing Provider's Medicaid Provider Number **87654321**	**999**

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**01/31/37**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A.	❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
V82.9 Unspecified condition		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	A0431					**21**	**Ambulance service, conventional air services, transport, one way (rotary wing)**	**1.0**	**XX.XX**
	A0436					**21**	**Rotary wing air mileage, per statute mile**	**60.0**	**XX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges**	**XX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M Requesting	**02/05/04**

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

❑ Approved

Grant Date

Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

SIGNATURE — Consultant / Analyst

Date Signed

ATTACHMENT 11
Prior Authorization Physician Attachment (PA/PA) Completion Instructions

(A copy of the "Prior Authorization Physician Attachment [PA/PA] Completion Instructions" is located on the following page.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA) COMPLETION INSTRUCTIONS

Complete the Prior Authorization Physician Attachment (PA/PA), including the Prior Authorization Request Form (PA/RF), and submit it by fax to (608) 221-8616. Providers also have the option of submitting PA requests by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers with questions about completing PA requests should call Provider Services at (800) 947-9627 or (608) 221-9883.

To obtain copies of PA forms, providers have the following options:

- Refer to the forms area of the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* to download the file and print it.
- Photocopy the attachment.
- Order copies by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

  Wisconsin Medicaid
  Form Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient (Last, First, Middle Initial)
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 2 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 3 — Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider (not required)

Element 5 — Performing Provider's Medicaid Number
Enter the eight-digit Medicaid provider number of the physician performing the service.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including area code, of the provider performing the service.

Element 7 — Name — Ordering / Prescribing Physician
Enter the name of the referring/prescribing physician in this element.

SECTION III — SERVICE INFORMATION

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete Elements A through C.
2. Read Element 22 of the PA/RF before signing and dating the PA/PA.
3. Sign and date the PA/PA (Element D).

ATTACHMENT 12
Prior Authorization Physician Attachment (PA/PA) (for photocopying)

(A copy of the "Prior Authorization Physician Attachment [PA/PA]" [for photocopying] is located on the following page.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to your service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Physician Attachment (PA/PA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth (MM/DD/YYYY)

3. Wisconsin Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

5. Performing Provider's Medicaid Number

6. Telephone Number — Performing Provider

7. Name — Ordering / Prescribing Physician

Continued on reverse

SECTION III — SERVICE INFORMATION

A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

B. Describe medical history pertinent to service or procedure requested.

C. Supply justification for service or procedure requested.

D. SIGNATURE — Physician	Date Signed