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and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Home Health Agencies
Individual Medical Supply Providers
Medical Equipment Vendors
Nurses In Independent Practice
Nursing Homes
Personal Care Agencies
Pharmacies
HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for disposable medical supplies as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for disposable medical supplies (DMS), 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 disposable medical supplies (DMS). 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 include:

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

Wisconsin Medicaid does not require PA for DMS unless quantity limits are exceeded or if the procedure code specifically indicates PA is required. Refer to the DMS Index for additional information.

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 DMS.

Allowable procedure codes

Wisconsin Medicaid will adopt Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W1226-W8300) for DMS. None of the "W" codes will be accepted after the implementation of HIPAA. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers must use the appropriate HCPCS procedure code that describes the DMS item.

As a reminder, a provider may only continue to request PA for the item by using the most appropriate not otherwise classified (NOC) procedure code if a provider cannot find a national HCPCS procedure code that describes the DMS being reported. This will apply to some items that were previously billed using a "W" code. Items billed using the NOC procedure code always require PA.

Providers should continue to refer to their service-specific handbook, DMS Index, and *Updates* for other nationally recognized procedure codes Wisconsin Medicaid covers.

Modifiers

Providers will be required to use nationally recognized HCPCS modifiers. Refer to Attachment 1 for the appropriate modifier to use with the particular procedure code for the specific DMS item.

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. Refer to Attachment 2 for a list of allowable POS codes for DMS.

Coverage for disposable medical supplies

Medicaid coverage and documentation requirements for DMS will remain unchanged. Refer to the Disposable Medical Supplies Handbook, DMS Index, and *Updates* for complete Medicaid policies and procedures.

Coverage of exceptional supplies

Effective with the implementation of HIPAA, Wisconsin Medicaid will cover exceptional supplies using procedure code E1399 "Durable medical equipment, miscellaneous" instead of the current local procedure code W6890.

Exceptional supplies are either DMS or durable medical equipment provided to nursing home recipients with certain medical conditions.

Exceptional supplies are either DMS or durable medical equipment provided to nursing home recipients with certain medical conditions. Providers should use E1399 for both purchased and rented exceptional supplies. To indicate rental items, providers will be required to use procedure code E1399 with rental modifier "RR." For purchase items, providers should indicate procedure code E1399 *without* modifier "RR." Refer to the Disposable Medical Supplies Handbook or Durable Medical Equipment Handbook and *Updates* for Medicaid policies and procedures for exceptional supplies.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified DMS 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 3 for the revised instructions. Attachment 4 is a sample of a claim for DMS that reflects the changes to the billing instructions.

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 CMS 1500 paper claim instructions 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 are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- Spenddown amount should 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.

The Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), HCF 11030, dated 06/03, has also been revised. The basic information requested on the form has not changed; only the format of the form has changed.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, DMS providers will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03, if PA is necessary. Instructions for completion of this revised form are located in Attachment 5. A sample PA/RF for DMS is in Attachment 6 and a sample PA/RF of exceptional supplies is in Attachment 7.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Requested start date field added (Element 14).
- Number of detail lines reduced from six to five (Elements 15-21).
- Space added for additional modifiers (Element 17).

Prior authorization attachments

The Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), HCF 11030, dated 06/03, has also been revised. The basic information requested on the form has not changed; only the format of the form has changed. Refer to Attachment 8 for a copy of the completion instructions for the PA/DMEA. Attachment 9 is a copy of the PA/DMEA for providers to photocopy.

Obtaining prior authorization request forms

The PA/DMEA 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/DMEA 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-

* 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.

outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/DMEA 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.
- *aspe.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/*.

ATTACHMENT 1
Procedure code conversion chart for disposable medical supplies

The following table lists the Healthcare Common Procedure Coding System (HCPCS) procedure codes and modifiers, if applicable, that providers will be required to use when submitting prior authorizations (PAs) and claims for disposable medical supplies (DMS). Refer to the user notes in brackets for Wisconsin Medicaid's description of the DMS item. 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). For other PA requirements, such as quantity limitations, providers should refer to the DMS Index that will be published prior to HIPAA implementation.

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
K0183		Nasal application device used with positive airway pressure device	**A7034**		Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
K0184		Nasal single piece interface, replacement for nasal application device, pair or single piece interface *[Nasal pillows/seals, replacement for nasal application device, pair or single piece interface]*	**A7032**		Replacement cushion for nasal application device, each
			A7033		Replacement pillows for nasal application device, pair
K0185		Headgear used with positive airway pressure device	**A7035**		Headgear used with positive airway pressure device
K0186		Chin strap used with positive airway pressure device	**A7036**		Chinstrap used with positive airway pressure device
K0187		Tubing used with positive airway pressure device	**A7037**		Tubing used with positive airway pressure device
K0188		Filter, disposable, used with positive airway pressure device	**A7038**		Filter, disposable, used with positive airway pressure device
K0189		Filter, nondisposable, used with positive airway pressure device	**A7039**		Filter, non disposable, used with positive airway pressure device
K0561		Ostomy skin barrier, non-pectin based, paste, per ounce	**A4405**		Ostomy skin barrier, non-pectin based, paste, per ounce
K0562		Ostomy skin barrier, pectin-based, paste, per ounce	**A4406**		Ostomy skin barrier, pectin-based, paste, per ounce
K0563		Ostomy skin barrier with flange (solid, flexible or accordion), extended wear, with built-in convexity, 4x4 inches or smaller, each	**A4407**		Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each
K0564		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4x4 inches, each	**A4408**		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
K0565		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each	**A4409**		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each
K0566		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4x4 inches, each	**A4410**		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
K0567		Ostomy pouch, drainable, with karaya based barrier attached, without built-in convexity, (one piece), each	**A5062**	**22**	Ostomy pouch, drainable; without barrier attached (one piece), each + Unusual Procedural Services modifier *[Ostomy pouch, drainable, with karaya-based barrier attached, without built-in convexity (one piece), each]*
K0568		Ostomy pouch, drainable, with standard wear barrier attached, without built-in convexity, (one piece), each	**A5062**	**59**	Ostomy pouch, drainable; without barrier attached (one piece), each + Distinct Procedural Service modifier *[Ostomy pouch, drainable, with standard wear barrier attached, without built-in convexity (one piece), each]*
K0570		Built-in convexity, 4x inches or smaller, each *[Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each]*	**A4414**		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each
K0571		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each	**A4415**		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each
K0572		Tape, non-waterproof, per 18 square inches	**A4450**		Tape, non-waterproof, per 18 square inches
K0573		Tape, waterproof, per 18 square inches	**A4452**		Tape, waterproof, per 18 square inches
K0574		Addition to ostomy pouch, filter, integral or added separately to pouch, each	**Discontinued**		
W1226		Container dispose 1 gal.	**T1999**	**U1**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[Biohazard disposable container, needle and syringe — 1 gal./medium]*
W1227		Container dispose 1 qt.	**Discontinued**		
W1228		Container dispose 2 qt.			
W1229		Container dispose 2 gal.	**T1999**	**U2**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[Biohazard disposable container, needle and syringe — 2 gal./large]*

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
W1230		Container dispose 8 gal.	**Discontinued**		
W1231		EZ/TT (insulin disposable) adapter			
W1232		IV adapter with injection sites	**T1999**	**U3**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV injection cap/site]*
W1233		IV administration drug reservoir bag	**T1999**	**U4**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV administration reservoir bag with or without tube]*
W1234		IV administration res cassette 100ml	**T1999**	**U5**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV administration cassette or reservoir]*
W1235		IV administration res cassette 50ml			
W1236		IV administration reservoir remote adapt			
W1237		IV administration reservoir bag with tube	**T1999**	**U4**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV administration reservoir bag with or without tube]*
W1238		IV administration set (pca)	**A4230**	**22**	Infusion set for external insulin pump, nonneedle cannula type + Unusual Procedural Services modifier *[IV administration set with or without filter, **specialty type**]*
W1239		IV administration set (pump set)			
W1240		IV administration set (secondary)	**S1015**		IV tubing extension set
W1241		IV administration set connector loop			
W1244		IV administration set LVP with filter	**A4230**	**22**	Infusion set for external infusion pump, nonneedle cannula type + Unusual Procedural Services modifier *[IV administration set with or without filter, **specialty type**]*
W1245		IV administration set LVP-ambulatory			
W1246		IV administration set with filter			
W1247		IV administration set Y-type	**A4231**	**22**	Infusion set for external insulin pump, needle type + Unusual Procedural Services modifier *[IV administration set with or without filter, **standard type**]*
W1249		IV administration Y-connector			
W1250		IV administration Y-Type access pin/valve	**Discontinued**		
W1251		IV administration set hypodermoclysis			

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
W1252		IV administration set microdrip	**A4231**	**22**	Infusion set for external insulin pump, needle type + Unusual Procedural Services modifier *[IV administration set with or without filter,* ***standard type****]*
W1254		IV administration set — piggyback	**S1015**		IV tubing extension set
W1255		IV administration kit with tube			
W1256		IV butterfly intermittent	**A4232**	**22**	Syringe with needle for external insulin pump, sterile, 3cc + Unusual Procedural Services modifier *[IV catheter or butterfly]*
W1257		IV button infuser	**Discontinued**		
W1258		IV cannula blunt	**T1999**	**U9**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV cannula]*
W1259		IV cath placement unit	**Discontinued**		
W1260		IV cath plug			
W1261		IV catheter	**A4232**	**22**	Syringe with needle for external insulin pump, sterile, 3cc + Unusual Procedural Services modifier *[IV catheter or butterfly]*
W1262		IV catheter clamp	**Discontinued**		
W1263		IV catheter intro needle			
W1264		IV catheter midline	**T1999**	**UA**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV catheter PICC/midline]*
W1265		IV catheter p-q set-up tray picc			
W1266		IV catheter picc line			
W1267		IV catheter white replacement connector	**T1999**	**UB**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector]*
W1268		IV connector female/female			
W1269		IV dispensing pin	**T1999**	**UC**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV dispensing pin]*
W1273		IV filter	**T1999**	**UD**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV filter]*
W1274		IV filter inline			
W1275		IV filter micro			

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
W1276		IV fluid dispense connector	**Discontinued**		
W1277		IV infuser w/huber needle			
W1278		IV needle infuser 0-60 min	**T1999**	**22**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Unusual Procedural Services modifier *[IV infuser device]*
W1279		IV infuser device >1 hr <24 hrs			
W1280		IV infuser device 24hr			
W1281		IV infuser device >24hr-48hr			
W1282		IV infuser device >48 hour			
W1283		IV infuser-patient control module			
W1284		IV injection cap	**T1999**	**U3**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV injection cap/site]*
W1285		IV injection site (vicra)			
W1286		IV lifeshield connector	**Discontinued**		
W1287		IV luer adapter	**T1999**	**UB**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector]*
W1288		IV needleless cannula	**T1999**	**U9**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV cannula]*
W1289		IV needleless injec site	**T1999**	**59**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Distinct Procedural Service modifier *[IV needleless injection site]*
W1290		IV needleless luer lok	**T1999**	**UB**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector]*
W1291		IV needleless system	**T1999**	**59**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Distinct Procedural Service *[IV needleless injection site]*
W1292		IV needleless threaded lok	**T1999**	**UB**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector]*

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
W1293		IV set with conn loop & injection site	**S1015**		IV tubing extension set
W1294		IV site cap male non-vent	**T1999**	**U6**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector/cap, male/female, luer/luerlock]*
W1295		IV site cap male/female conn.			
W1296		IV start kit (no cath)	**A4232**	**22**	Syringe with needle for external insulin pump, sterile, 3cc + Unusual Procedural Services modifier *[IV catheter or butterfly]*
W1297		IV transfer set	**A4231**	**22**	Infusion set for external insulin pump, needle type + Unusual Procedural Services modifier *[IV administration set with or without filter,* ***standard type****]*
W1298		IV transfer set w/needle	**Discontinued**		
W1299		IV universal cath accessory port			
W1300		IV value luer tapered	**T1999**	**U6**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector/cap, male/female, luer/luerlock]*
W1301		IV vial adapter	**T1999**	**U7**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV vial adapter]*
W1302		Male/female luerlock cap	**T1999**	**U6**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[IV connector/cap, male/female, luer/luerlock]*
W1303		Needle (huber)	**A4215**	**59**	Needles only, sterile, any size, each + Distinct Procedural Service modifier *[Huber needle]*
W1304		Needle (huber) 6"			
W1305		Needle (huber) 7"			
W1306		Needle filter 1 1/2"	**T1999**	**U8**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[Needle filter 1½"]*
W1307		Needle, cath strgt metal hub	**Discontinued**		
W1309		Needles reusable			
W1310		Novofine 30 needle disp	**A4215**	**22**	Needles only, sterile, any size, each + Unusual Procedural Services modifier *[Insulin pen needles]*

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
W1312		Novopen 1.5 insulin device	**A4258**	**22**	Spring-powered device for lancet, each + Unusual Procedural Services modifier *[Insulin pen]*
W1313		Pen pump infuser catheter set	**Discontinued**		
W1314		Pen pump infuser comb. unit			
W1322		Syringe 50/60cc	**A4213**	**59**	Syringe, sterile, 20 cc or greater, each + Distinct Procedural Service modifier *[Syringe 50/60 cc]*
W6400		Applicators	**A4626**	**59**	Tracheostomy cleaning brush, each + Distinct Procedural Service modifier *[Applicators]*
W6401		Skin level gastrostomy feeding tube kit *[Requires prior authorization]*	**B4086**	**59**	Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each + Distinct Procedural Service modifier *[Skin level gastrostomy feeding tube kit (requires prior authorization)]*
W6403		Cotton balls per 100	**A4626**	**22**	Tracheostomy cleaning brush, each + Distinct Procedural Service modifier *[Cotton balls per 100]*
W6404		Disposable diapers, each			
	10	Disposable diapers, adult, small, each	**A4522**		Adult-sized incontinence product, diaper, medium size, each
	20	Disposable diapers, adult, medium, each			
	30	Disposable diapers, adult, large, each	**A4523**		Adult-sized incontinence product, diaper, large size, each
	40	Disposable diapers, children, under 30 pounds, each	**A4529**		Child-size incontinence product, diaper, small/medium size, each
	50	Disposable diapers, children, over 30 pounds, each			
W6405		Ear plugs, pair	**Discontinued**		
W6406		Enema bags/drains/sets	**A4458**		Enema bag with tubing, reusable
W6410		Disposable diaper liners, each	**A4529**	**22**	Child-sized incontinence product, diaper, small/medium size, each + Unusual Procedural Services modifier *[Disposable diaper liners, each]*

Before HIPAA implementation			After HIPAA implementation		
Procedure code	**Modifier**	**Procedure code description *[user notes]***	**HCPCS procedure code**	**National modifier**	**HCPCS procedure code description + national modifier description *[user notes]***
W6411		Tracheostomy supplies			
	20	Trach plug	**A4621**	**59**	Tracheostomy mask or collar + Distinct Procedural Service modifier *[Trach plug]*
	40	Precut gauze trach dressing	**A6402**	**59**	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing + Distinct Procedural Service modifier *[Precut gauze trach dressing]*
	70	Sterile water and reservoir	**A7020**	**22**	Sterile water or sterile saline, 1000 ml, used with large volume nebulizer + Unusual Procedural Services modifier *[Sterile water, heated humidifier use, 1650-2000 cc]*
				59	Sterile water or sterile saline, 1000 ml, used with large volume nebulizer + Distinct Procedural Service modifier *[Sterile water/autofeed/heated humidifier use, 1650-2000 cc]*
W6413		Ventilator bacteria filter	**A7013**	**59**	Filter, disposable, used with aerosol compressor + Distinct Procedural Service modifier *[Ventilator bacteria filter]*
W6499		Not otherwise classified — disp supplies — requires PA	**T1999**	**SC**	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" + Locally Defined National Modifier for DMS *[Short description: NOC retail supplies]*
W6603		Binder Velcro or strap closure	**A4462**		Abdominal dressing holder, each
W6890		DME ventilator/exceptional supply needs for nursing home recipients *[Exceptional supplies]*	**E1399**		Durable medical equipment, miscellaneous *[Exceptional supplies]*
W6911		Battery, hearing aid: Silver 675	**V5266**		Battery for use in hearing device
W6912		Battery, hearing aid: Silver 13			
W6927		Battery, hearing aid: Silver 312			
W6940		Battery, hearing aid, Zinc Air 10			
W6941		Battery, hearing aid, Zinc Air 5			
W6943		Battery, hearing aid: Zinc-Air 13			
W6944		Battery, hearing aid: Zinc-Air 675			
W6955		Battery, hearing aid: Zinc-Air 312			
W8300		Unspecified enteral nutrition product used by provider for products not Medicare assigned	**Discontinued**		
Y4100		Gastrostomy tube, silicone with sliding ring			

ATTACHMENT 2
Place of service codes for disposable medical supplies

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 disposable medical supplies. 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).

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
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 3
CMS 1500 claim form instructions for disposable medical supplies
(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denial 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 "D" in the Medicaid check box for the service billed.

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

Home health agency, medical equipment vendor, pharmacy, and physician services providers must be Medicare enrolled to provide Medicare-covered services for dual entitlees. Dual entitlees are those recipients covered under both Medicare and 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 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

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure/item description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s)/item(s). In this instance, indicate "See Attachment" in Element 19.

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 for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

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 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 for each service. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS for disposable medical supplies.

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
Enter an "F" for each family planning procedure. If family planning does not apply, leave this element blank.

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. The 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 4
Sample CMS 1500 claim form for disposable medical supplies

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [D] | 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 [X]

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

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 ________

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO — $ CHARGES

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

1. 681.01
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

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 01 03		12		T1999	U3	1	XXX XX	50.0				
2													
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. Authorized — MM/DD/YY

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. Authorized
1 W. Williams
Anytown, WI 55555 — 87654321

PIN# — GRP#

(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 5
Prior Authorization Request Form (PA/RF) Completion Instructions for disposable medical supplies

(For prior authorizations 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 the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send 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).

Note: Wisconsin Medicaid accepts PA requests with a maximum of 12 details per PA number. The Wisconsin Medicaid PA/RF has space for five items. If a provider's PA request requires more than five items to be listed, the provider may continue the PA request on a second and third PA/RF. When submitting a PA request with multiple pages, indicate the page number and total number of pages for the PA/RF in the upper right hand corner (e.g., "page 1 of 2" and "page 2 of 2"). On the form(s) used for page 2 and, if appropriate, page 3, cross out the seven-digit PA number and write the PA number from the first form.

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 the appropriate three-digit processing type from the list below. The processing type is a three-digit code used to identify a category of service requested. Use processing type "999" (Other) only if the requested category of service is not found in the list. Prior authorization requests will be returned without adjudication if no processing type is indicated.

132 — Disposable Medical Supplies (DMS).
139 — Exceptional supplies.
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 correspond with 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 appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Note: Medical vendors and individual medical supply providers may provide only a written description.

Element 11 — Start Date — SOI (not required)

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

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Note: Medical vendors and individual medical supply providers may provide only a written description.

Element 14 — Requested Start Date (not required)
If appropriate, enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested.

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the provider who will be performing the service *only* if this number is different from the billing provider number listed in Element 4.

Element 16 — Procedure Code
Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) code for each service/item requested.

Element 17 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS
Enter the appropriate place of service (POS) code designating where the requested service/item would be provided/performed/dispensed. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS for DMS.

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

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

Element 21 — Charge
Enter the usual and customary charge for each service/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/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 Charges
Enter the anticipated total charge for this request. If providers completed additional PA/RFs, the total charges should be indicated in Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 should refer to the last page (for example, "SEE PAGE 2.")

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 6
Sample Prior Authorization Request Form (PA/RF) for disposable medical supplies

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 1 W. Williams Anytown, WI 55555	(XXX) XXX-XXXX 4. Billing Provider's Medicaid Provider Number 12345678	132

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	MM/DD/YY	609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.	9. Sex — Recipient ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
250.01 Diabetes mellitus		
13. Diagnosis — Secondary Code and Description 595.9 Cystitis, unspecified	14. Requested Start Date 11/01/03	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	A4253	KX				12	Blood glucose test strips	5	XXX.XX
	A4259	KX				12	Lancets	3	XXX.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** XXX.XX

23. **SIGNATURE** — Requesting Provider I.M. Provider

24. Date Signed MM/DD/YY

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 7
Sample Prior Authorization Request Form (PA/RF) for exceptional supplies

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)
I. M. Provider
1 W. Williams
Anytown, WI 55555

2. Telephone Number ? Billing Provider
(XXX) XXX-XXXX

3. Processing Type
139

4. Billing Provider's Medicaid Provider Number
12345678

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number
1234567890

6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY

7. Address — Recipient (Street, City, State, Zip Code)
609 Willow
Anytown, WI 55555

8. Name — Recipient (Last, First, Middle Initial)
Recipient, Im A.

9. Sex — Recipient
❑ M ☒ F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description
518.81 Acute respiratory failure

11. Start Date — SOI

12. First Date of Treatment — SOI

13. Diagnosis — Secondary Code and Description
V55.0 Tracheostomy

14. Requested Start Date
12/01/03

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	E1399					31	Trach care kit BID	60	XXX.XX
	E1399					31	Trach suction catheter/every shift	90	XXX.XX
	E1399					31	Trach tube holder every 3 days	10	XXX.XX
	E1399	RR				31	Compressor	30	XXX.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** XXX.XX

23. **SIGNATURE** — Requesting Provider I.M. Provider

24. Date Signed
MM/DD/YY

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 8
Prior Authorization / Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions

(A copy of the "Prior Authorization/Durable Medical Equipment Attachment [PA/DMEA] Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA) COMPLETION INSTRUCTIONS

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 mandatory when requesting PA for durable medical equipment (DME).

INSTRUCTIONS: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested equipment or supplies. If necessary, attach additional pages for the provider's responses and/or an occupational or physical therapy report if available. All DME, including repairs, must be prescribed by a physician. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements.

Attach a photocopy of the physician's prescription to the completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA). The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid. Attach the PA/DMEA 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

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification 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 to obtain the correct identification number.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 5 — Prescribing Physician's Medicaid Provider No.
Enter the eight-digit Medicaid provider number of the prescribing physician. The provider number in this element must correspond with the provider name listed in Element 4.

Element 6 — Telephone Number — Prescribing Physician
Enter the prescribing physician's telephone number, including area code.

Element 7 — Telephone Number — Dispensing Physician
Enter the dispensing physician's telephone number, including area code.

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SECTION III — SERVICE INFORMATION

Element 8
Describe the overall physical status of the recipient (mobility, self-care, strength, coordination).

Element 9
Describe the medical condition of the recipient as it relates to the equipment/item requested. Indicate why the recipient needs this equipment.

Element 10
Indicate if the recipient is able to operate the equipment/item requested.

Element 11
Indicate if the training is provided or required.

Element 12
State where equipment/item will be used. Describe type of dwelling and accessibility.

Element 13
State estimated duration of need.

Element 14
If renewal or continuation of DME authorization is requested, describe the following about the recipient, including current clinical condition, progress (improvement, no change, etc.), results, and the recipient's use of equipment/item prescribed.

Element 15
Indicate amount of oxygen to be administered.

Element 16 — Signature — Requesting Provider
Enter the signature of the requesting provider.

Element 17 — Date Signed
Enter the month, day, and year the PA/DMEA was signed (in MM/DD/YYYY format).

Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid.

ATTACHMENT 9
Prior Authorization / Durable Medical Equipment Attachment (PA/DMEA) (for photocopying)

(A copy of the "Prior Authorization/Durable Medical Equipment Attachment [PA/DMEA]" [for photocopying] is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11030 (Rev. 06/03)

STATE OF WISCONSIN
HFS 107.24(3), Wis. Admin. Code

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)

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 the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions (HCF 11030A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Prescribing Physician	5. Prescribing Physician's Medicaid Provider No.
6. Telephone Number — Prescribing Physician	7. Telephone Number — Dispensing Provider

SECTION III — SERVICE INFORMATION

8. Describe the overall physical status of the recipient (mobility, self-care, strength, coordination).

9. Describe the medical condition of the recipient as it relates to the equipment / item requested (e.g., describe why the recipient needs this equipment).

10. Is the recipient able to operate the equipment / item requested?
- ❑ Yes
- ❑ No — If not, who will do this?

Continued

SECTION III —SERVICE INFORMATION (Continued)

11. Is training provided or required?

❑ Yes ❑ No — If not, who will do this?

Explain:

12. State where equipment / item will be used.

❑ Home ❑ Office
❑ Nursing Home ❑ Job
❑ School

Describe type of dwelling and accessibility.

13. State estimated duration of need.

14. If renewal or continuation of DME authorization is requested, describe the following about the recipient, including current clinical condition, progress (improvement, no change, etc.), results, and the recipient' s use of equipment / item prescribed.

15. Indicate amount of oxygen to be administered.

____ Liters per minute _____ Continuous

____ Hours per day _____ PRN

____ Days per week _____ PaO_2

Attach a photocopy of the physician' s prescription to this attachment. The prescription must be signed and dated within six mon ths of receipt by Wisconsin Medicaid.

16. **SIGNATURE** —Requesting Provider	17. Date Signed