wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
- Home Health Agencies
- Individual Medical Supply Providers
- Medical Equipment Vendors
- Nursing Homes
- Occupational Therapists
- Pharmacies
- Physical Therapists
- Rehab Agencies
- Speech-Language Pathologists
- Therapy Groups
- HMOs and Other Managed Care Programs

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

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for durable medical equipment (DME), 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 form 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 durable medical equipment (DME). 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 form 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 DME.

Allowable procedure codes

Wisconsin Medicaid will adopt Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W0905-W6890) for DME. None of the "W" codes will be accepted by Wisconsin Medicaid

after the implementation of HIPAA. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers must use the appropriate HCPCS or CPT procedure code that describes the DME item.

Changes to Wisconsin Medicaid due to HIPAA will result in some changes for DME, including the following:

- In a limited number of instances, the new nationally recognized code might affect PA requirements for Wisconsin Medicaid.
- In a limited number of instances, the new nationally recognized code might change whether Wisconsin Medicaid covers purchase or rental of a particular item. Refer to the "Purchase/Rental" column in Attachment 1 for more information.

Providers will only be able to use a not otherwise classified (NOC) procedure code if no national HCPCS or CPT procedure code describes the equipment being issued/ prescribed. With the implementation of HIPAA, some items previously billed using a "W" code may only be billed by using an NOC procedure code. Items billed using an NOC procedure code always require PA.

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

Modifiers

Providers will be required to use nationally recognized modifiers, including the following:

- "50" for bilateral procedure.
- "59" for distinct procedural service.
- "RR" for rental.
- "U1" through "UD" as assigned by Wisconsin Medicaid on the approved PA requests to indicate item number.

Refer to the following conversion charts for more information:

- Attachment 2 for a conversion chart from type of service to nationally recognized modifiers.
- Attachment 3 for a conversion chart from local modifiers to nationally recognized modifiers.
- Attachment 4 for a conversion chart for item number modifiers.

Type of service codes

Type of service codes will no longer be required on Medicaid claims and PA requests. To indicate rental of DME, providers are required to use modifier "RR" with the procedure code. For purchase of DME, providers should indicate the procedure code *without* modifier "RR."

To indicate rental of DME, providers are required to use modifier "RR" with the procedure code. For purchase of DME, providers should indicate the procedure code *without* modifier "RR."

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 5 for a list of allowable POS codes for DME.

Coverage for durable medical equipment

Medicaid coverage of DME will remain unchanged. Refer to the Durable Medical Equipment Handbook, DME 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 DME or disposable medical supplies (DMS) 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 are required to use procedure code E1399 with modifier "RR." For purchase items, providers should indicate procedure code E1399 *without* modifier "RR." Refer to the Durable Medical Equipment Handbook, DME Index, Disposable Medical Supplies Handbook, DMS Index, and *Updates* for Medicaid policies and procedures for exceptional supplies.

Revision of CMS 1500 paper claim 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.

With the implementation of HIPAA, Medicaid-certified providers are 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. Attachment 7 is a sample of a claim for DME 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 form 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.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, DME 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 8. A sample PA/RF for DME is in Attachment 9, and a sample PA/RF for exceptional supplies 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 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 11 for a copy of the completion instructions for the PA/DMEA. Attachment 12 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-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

Changes to STAT-PA as a result of HIPAA will be addressed in a future *Update.*

Changes to STAT-PA

Although there will be some changes, Wisconsin Medicaid will continue to use Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) with the implementation of HIPAA. Changes to STAT-PA as a result of HIPAA will be addressed in a future *Update.*

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

* 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.

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 durable medical equipment

The following table lists the nationally recognized procedure codes and modifiers, if applicable, that providers will be required to use when submitting prior authorizations (PAs) and claims for durable medical equipment (DME). 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 life expectancy limitations, providers should refer to the DME Index that will be published prior to HIPAA implementation.

Before HIPAA implementation		**After HIPAA implementation**		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
E1230-30	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number *[Rear Wheel Drive]*	**E1230-59**	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number *[Rear Wheel Drive]*	Purchase or Rental
W0905	Bathroom equipment, includes: rails, seats, stools, benches, any type	**E0241**	Bathtub wall rail, each	Purchase
		E0242	Bathtub rail, floor base	
		E0243	Toilet rail, each	
		E0244	Raised toilet seat	
		E0245	Tub stool or bench	Purchase or Rental
		E0246	Transfer tub rail attachment	Purchase
W0915	Automated medication dispenser	**E1399**	Durable medical equipment, miscellaneous	Purchase or Rental
W0916	Strobe light only allowed with purchased automated medication dispenser for deaf patients.	**Discontinued**		
W6600	Orthotic cast procedures			
W6603	Binder Velcro or strap closure	**Discontinued as DME. Refer to Disposable Medical Supplies Index.**		
W6626	AFO; custom molded plastic, long inhibitory type, constructed around malleoli, with pelite inserts, leather forefoot extension, over cast	**L1945**	AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated	Purchase
W6640	Prosthetic cast procedures	**Discontinued**		
W6704	Suction pump, portable (includes battery, battery charger and DC cord)	**E0600**	Respiratory suction pump, home model, portable or stationary, electric	Purchase or Rental

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
W6717	Rim head control	**K0108**	Other accessories *[Wheelchair component or accessory, not otherwise specified]*	Purchase
W6718	Power recline, complete, includes cables, electronics, interface and hardware			
W6725	Sectional height back			
W6727	Chin or mouth control assembly with on/off switch			
W6729	Wheelchair side panels, (including all special heights and heavy duty), each			
W6730	Electronics unit for patient owned power wheelchair, temporary use	**Discontinued**		
W6744	Adjustable scoliosis system	**L1005**	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment	Purchase
W6756	Cloth diapers (1 dozen)	**Discontinued**		
W6771	ThAIRapy bronchial drainage system, Vest	**E0483**	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each *[Wisconsin Medicaid reimburses for rental only.]*	Rental
W6772	ThAIRapy bronchial drainage system, generator			
W6774	Specialized vehicle seat	**E1399**	Durable medical equipment, miscellaneous	Purchase or Rental
W6776	Pulse oximeter (includes cord, batteries, alarm, sensors, printer and all supplies)	**E0445**	Oximeter device for measuring blood oxygen levels non-invasively	Purchase or Rental
W6778	Respirometer	**E1399**	Durable medical equipment, miscellaneous *[Must specify]*	Purchase or Rental
W6779	Analyzer, oxygen			
W6780	CO_2 respiration monitor, including all accessories			
W6782	Humidifier — heated	**K0531**	Humidifier, heated, used with positive airway pressure device	Purchase or Rental
W6783	Concha-Pack humidifier (heated)	**E0550**	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery	Purchase or Rental
W6785	Respirator (portable or stationary)	**E0450**	Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube) *[Wisconsin Medicaid reimburses for rental only]*	Rental

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
W6788	Exsufflation Belt	**Discontinued**		
W6789	Blower			
W6790	Hose assembly (respiratory hose assemblies, permanent, reusable for IPPS, respirators, chest shells, respiratory wraps)			
W6792	Resuscitator — portable manual without case	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6793	Croup pediatric tent	**Discontinued**		
W6794	Mist tent with supplies			
W6795	Peak flowmeter, in-line, non-disposable, measure exhalatory flow rate (to be used as part of a respiratory system)			
W6796	Oximetry test			
W6797	Oximetry trending sleep study			
W6800	Enuretic alarm	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6801	Face guard for cervical craniostenosis, helmet (including chin strap)	**E0701**	Helmet with face guard and soft interface material, prefabricated	Purchase
W6802	Bath chair (e.g., lounge-type-TLC chair)	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6803	Rubber bed sheet, full-sized	**Discontinued**		
W6804	Miscellaneous parts used in the repair of equipment. (*Note:* This code is to be used only when there are no other codes available which describe the parts used in the repair.)	**K0108**	Other accessories	Purchase
		E1399	Durable medical equipment, miscellaneous	Purchase
W6805	Child's commode	**E0163**	Commode chair, stationary, with fixed arms	Purchase
		E0164	Commode chair, mobile, with fixed arms	
		E0165	Commode chair, stationary, with detachable arms	
		E0166	Commode chair, mobile, with detachable arms	
		E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	
W6806	Commode, toilet shower commode chair	**E0163**	Commode chair, stationary, with fixed arms	Purchase
		E0164	Commode chair, mobile, with fixed arms	
		E0165	Commode chair, stationary, with detachable arms	
		E0166	Commode chair, mobile, with detachable arms	
		E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
W6807	Commode, rehabilitation shower commode chair	**E0163**	Commode chair, stationary, with fixed arms	Purchase
		E0164	Commode chair, mobile, with fixed arms	
		E0165	Commode chair, stationary, with detachable arms	
		E0166	Commode chair, mobile, with detachable arms	
		E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	
W6809	Specialized hospital bed or crib, size 36x80 or adult sized, with mattress, crib sides and enclosed top	**E0250**	Hospital bed, fixed height, with any type side rails, with mattress *[bill this procedure code with E0316]*	Purchase
		E0251	Hospital bed, fixed height, with any type side rails, without mattress *[bill this procedure code with E0316]*	
		E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress *[bill this procedure code with E0316]*	
		E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress *[bill this procedure code with E0316]*	
		E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress *[bill this procedure code with E0316]*	
		E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress *[bill this procedure code with E0316]*	
		E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress *[bill this procedure code with E0316]*	
		E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress *[bill this procedure code with E0316]*	
		E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress *[bill this procedure code with E0316]*	
		E0290	Hospital bed, fixed height, without side rails, with mattress *[bill this procedure code with E0316]*	
		E0291	Hospital bed, fixed height, without side rails, without mattress *[bill this procedure code with E0316]*	

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
W6809 (cont.)	Specialized hospital bed or crib, size 36x80 or adult sized, with mattress, crib sides and enclosed top	**E0292**	Hospital bed, variable height, hi-lo, without side rails, with mattress *[bill this procedure code with E0316]*	Purchase
		E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress *[bill this procedure code with E0316]*	
		E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress *[bill this procedure code with E0316]*	
		E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress *[bill this procedure code with E0316]*	
		E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress *[bill this procedure code with E0316]*	
		E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress *[bill this procedure code with E0316]*	
		E0316	Safety enclosure frame/canopy for use with hospital bed, any type	
W6813	Specialized hydraulic or battery-operated bath lift	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6814	Grabbers — each	**E0241**	Bathtub wall rail, each	Purchase
		E0242	Bathtub rail, floor base	
		E0243	Toilet rail, each	
		E0246	Transfer tub rail attachment	
W6817	Pneumogram/pediscan test — 12 or 24 hour (includes rental of apnea monitor, recorder, 12 or 24-hour tape and professional services)	**Discontinued**		
W6822	Gastro intestinal suction machine	**E2000**	Gastric suction pump, home model, portable or stationary, electric	Purchase or Rental
W6823	Enteral feeding tube (weighted)	**Discontinued**		
W6824	Shower hose, includes diverter spout	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6827	Transfer tub bench	**E1399**	Durable medical equipment, miscellaneous	Purchase or Rental

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
W6828	Oxicardio Respirogram (includes rental of apnea monitor, recorder and oximeter, 12 or 24-hour tape and professional services)	**Discontinued**		
W6830	Reverse wheeled walker	**E0143**	Folding walker, wheeled, without seat	Purchase or Rental
W6832	Hand cone	**L3999**	Upper limb orthosis, NOS	Purchase
W6835	Adaptive eating utensils	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6836	Rocker knife			
W6837	Adaptive scoop dish			
W6838	Universal cuff			
W6839	Dycem mat			
W6840	Adaptive dressing aid			
W6841	Reacher			
W6842	Stocking aid			
W6843	Adaptive hygiene equipment			
W6844	Adaptive writing/typing aid	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6845	Adaptive cup/glass			
W6846	Plate/food guard			
W6847	Prone standers — small			
W6848	Prone standers — medium			
W6849	Adaptive/positioning equipment, not otherwise classified			
W6850	Prone standers — large			
W6856	Sling for patient lift, commode opening	**E0621-59**	Sling or seat, patient lift, canvas or nylon *[with commode opening]*	Purchase
W6857	Tilt-in-space, power, complete, includes cables, electronics, interface and hardware	**K0108**	Other accessories	Purchase
W6858	Supine board	**E1399**	Durable medical equipment, miscellaneous	Purchase
W6859	Mag, wheel, each	**K0108**	Other accessories	Purchase
W6860	Standing frame	**L1510**	THKAO, standing frame, with or without tray and accessories	Purchase

Before HIPAA implementation		After HIPAA implementation		
Local procedure code	**Local procedure code description *[user notes]***	**National procedure code**	**National procedure code description *[user notes]***	**Purchase/Rental**
W6862	Patient lift; bathroom or toilet, with seat or sling-chains	**E0630**	Patient lift, hydraulic, with seat or sling	Purchase or Rental
		E0635	Patient lift, electric, with seat or sling	
W6863	Enteral nutrition infusion pump, portable, (e.g., pet or companion)	**B9002**	Enteral nutrition infusion pump — with alarm	Purchase or Rental
W6865	AFO; molded to patient model, plastic, rigid anterial tibial section, (Floor reaction)	**L1945**	AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated	Purchase
W6866	Nebulizer AC/DC and/or battery power source with case	**E0571**	Aerosol compressor, battery powered, for use with small volume nebulizer	Purchase or Rental
W6872	Extra-uterine monitor	**E1399**	Durable medical equipment, miscellaneous	Rental
W6890	DME ventilator/exceptional supply needs for nursing home recipients	**E1399**	Durable medical equipment, miscellaneous	Purchase or Rental

ATTACHMENT 2
Type of service conversion chart for durable medical equipment

The following table lists the nationally recognized two-digit modifier codes that durable medical equipment providers are required to use instead of type of service (TOS) codes used currently. 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 TOS code and description	**National modifier and description**
P Purchase	**None** Leave blank
R Rental	**RR** Rental

ATTACHMENT 3
Modifier conversion chart for durable medical equipment

The following table lists the nationally recognized two-digit modifier codes that durable medical equipment providers are required to use instead of the local modifier codes used currently. 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 modifier and description	**National modifier and description**
01 Bilateral	**50** Bilateral Procedure
30 Rear Wheel Drive	**59** Distinct Procedural Service

ATTACHMENT 4
Item number modifier conversion chart for durable medical equipment

The following table lists the nationally recognized two-digit modifier codes for item numbers that providers are required to use for durable medical equipment *claims.* Wisconsin Medicaid will assign item numbers on approved prior authorizations. For items 14 through 25, providers will be required to list two national modifiers to accurately designate the item number. 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 modifier and description	**National modifier and description**
11 First Item	**U1** First Item
12 Second Item	**U2** Second Item
13 Third Item	**U3** Third Item
14 Fourth Item	**U4** Fourth Item
15 Fifth Item	**U5** Fifth Item
16 Sixth Item	**U6** Sixth Item
17 Seventh Item	**U7** Seventh Item
18 Eighth Item	**U8** Eighth Item
19 Ninth Item	**U9** Ninth Item
20 10th Item	**UA** 10th Item
21 11th Item	**UB** 11th Item
22 12th Item	**UC** 12th Item
23 13th Item	**UD** 13th Item

Before HIPAA implementation	**After HIPAA implementation**
Local modifier and description	**National modifiers and description**
24 14th Item	**UD** + **U1** 14th Item
25 15th Item	**UD** + **U2** 15th Item
26 16th Item	**UD** + **U3** 16th Item
27 17th Item	**UD** + **U4** 17th Item
28 18th Item	**UD** + **U5** 18th Item
29 19th Item	**UD** + **U6** 19th Item
30 20th Item	**UD** + **U7** 20th Item
31 21st Item	**UD** + **U8** 21st Item
32 22nd Item	**UD** + **U9** 22nd Item
33 23rd Item	**UD** + **UA** 23rd Item
34 24th Item	**UD** + **UB** 24th Item
35 25th Item	**UD** + **UC** 25th Item

ATTACHMENT 5
Place of service codes for durable medical equipment

The following table lists the nationally recognized two-digit place of service (POS) codes that will replace the one-digit POS codes used currently. 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
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
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
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

ATTACHMENT 6
CMS 1500 claim form instructions for durable medical equipment

(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 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.

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-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 date of service (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 5 of this *Wisconsin Medicaid and BadgerCare Update* for a list of valid POS codes.

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." (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) 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
If the services were provided to a recipient in a nursing home, indicate the nursing home's eight-digit Wisconsin Medicaid provider number.

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

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, address, 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 durable medical equipment

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [D] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (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 _____

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 MM DD YY FROM TO MM DD YY

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

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. 519.02
2. 530.3
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 01 01 04	30	12		B9002	RR	1	XXX.XX	30.0				
2 01 01 04	30	12		E0600	RR	1	XXX.XX	30.0				
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: $ XXX XX

30. BALANCE DUE: $ XXX 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 8
Prior Authorization Request Form (PA/RF) Completion Instructions for durable medical equipment

(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.

Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests.

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 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).

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.

130 — Durable Medical Equipment (DME) (wheelchairs, accessories, home health equipment)
139 — DME (respiratory equipment or exceptional supplies)
140 — DME (orthotics, footwear, prosthetics)
999 — Other

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: Pharmacists, medical equipment 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: Pharmacists, medical equipment vendors, and individual medical supply providers may provide only a written description.

Element 14 — Requested Start Date (not required)

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code
Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure 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 code designating where the requested service/item would be provided/performed/dispensed.

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

Element 20 — QR
Enter the appropriate quantity (e.g., number of services) 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 9
Sample Prior Authorization Request Form (PA/RF) for durable medical equipment

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**	**130**
	4. Billing Provider's Medicaid Provider Number **12345678**	

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 — Recipier ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
436 Acute, but ill-defined cerebrovascular disease		
13. Diagnosis — Secondary Code and Description **342.9 Hemiplegia, unspecified**	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
	K0004					**12**	**High strength, lightweight wheelchair Invacare Patriot**	**1**	**XXXX.XX**
	E0192					**12**	**Jay active cushion**	**1**	**XXX.XX**
	K0108					**12**	**Headrest with hardware**	**1**	**XXX.XX**
	K0108					**12**	**Custom drop seat**	**1**	**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** **X,XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**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 10
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)	2. Telephone Number? Billing Provider	3. Processing Type
I. M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**139**
	4. Billing Provider's Medicaid Provider Number **12345678**	

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 — Recipier ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
518.81 Acute respiratory failure		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
V55.0 Tracheostomy	**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	24. Date Signed
I.M. Provider	**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 11
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.)

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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 12
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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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 months of receipt by Wisconsin Medicaid.

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