wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Nursing Homes
HMOs and Other Managed Care Programs

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

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

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 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 nursing home services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are *not* policy or coverage related (e.g., PA requirements, documentation requirements), but include:

- Adopting nationally recognized procedure codes and place of service (POS) codes to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 paper claim instructions.
- Revising PA request forms and instructions.

Information about durable medical equipment (DME), disposable medical supplies (DMS), physical and occupational therapies, and speech and language pathology (SLP) for nursing home providers regarding changes due to HIPAA may be found in the *Updates* specific to those services.

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 nursing home services.

Allowable revenue codes

Wisconsin Medicaid will adopt *four-digit* National Uniform Billing Committee (NUBC) revenue codes to replace currently used two-digit nursing home level of care codes.

Note: NUBC revenue codes are expanding from a three-digit number format to a four-digit number format. Providers will be required to submit claims with the new four-digit revenue codes to avoid claim denials.

Providers should be aware that there will no longer be a code used to bill nursing home Medicare coinsurance days; coinsurance days should not be indicated on the UB-92 claim form. Also, the national condition code "A5" has been added to certain national revenue codes to more adequately describe the condition of a Medicaid recipient with a disability.

Refer to Attachment 1 of this *Update* for a revenue code conversion chart. Providers should use the appropriate NUBC revenue code that best describes the service performed.

Value codes

Providers billing for patient liability must not use local value code "84" on claims or adjustments effective October 2003. Wisconsin Medicaid is changing the way nursing home providers indicate patient liability on all claims and adjustments. Nursing home providers have already been notified of this change through the June 2003 *Update* (2003-32), titled "Changes to patient liability billing due to HIPAA."

Coverage for nursing home services

Medicaid coverage and documentation requirements for nursing home providers remain unchanged. Refer to the Nursing Home Services Handbook and *Updates* for complete Medicaid policies and procedures.

For information about changes due to HIPAA that effect DME, DMS, and physical, occupational, and SLP therapies for nursing home providers, refer to service-specific HIPAA *Updates* for these topics, ***not*** the Nursing Home Services Handbook.

Revision of UB-92 paper claim instructions

With the implementation of HIPAA, Medicaid-certified nursing homes will be required to follow the revised instructions for the UB-92 paper claim form in this *Update,* even though the actual UB-92 claim form is not being revised at this time. Refer to Attachment 2 for the revised instructions. Attachment 3 is a sample of a straight Wisconsin Medicaid claim involving Medicare Part A Coinsurance Days. Providers will no longer need to indicate Medicare coinsurance days on a straight claim. Attachment 4 is a sample of a standard Wisconsin Medicaid claim with Bedhold Days. Both samples reflect the changes to the billing instructions for nursing homes.

With the implementation of HIPAA, Medicaid-certified nursing homes will be required to follow the revised instructions for the UB-92 paper claim form in this *Update,* even though the actual UB-92 claim form is not being revised at this time.

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 UB-92 claim form instructions

Revisions to the UB-92 paper claim form instructions include the following:

- Covered days for inpatient claims clarified (Form Locator 7).
- Revenue codes revised (Form Locator 42).
- Payer revised. If applicable, enter "patient liability amount" to identify any patient liability. (Form Locator 50 A-C).

Type of service codes will no longer be required on Medicaid PA requests for nursing home services.

- Estimated amount due revised. If applicable, enter the dollar amount of any patient liability. (Form Locator 55 A-C & P).
- Insured's name no longer required (Form Locator 58 A-C).
- Other diagnosis codes clarified (Form Locators 68-75).
- Medicare and other insurance disclaimer codes revised (Form Locator 84).

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, nursing home providers submitting PA requests on paper 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 5. A sample PA/RF is in Attachment 6.

Type of service codes

Type of service codes will no longer be required on Medicaid PA requests for nursing home services.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes as follows:

Code	Description
31	Skilled Nursing Facility
32	Nursing Facility
54	Intermediate Care Facility/Mentally Retarded

Revisions made to the Prior Authorization Request Form

The PA/RF has been revised to include a requested start date field (Element 14).

Prior authorization attachments

The Prior Authorization Physician Attachment (PA/PA) 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 7 for a copy of the completion instructions for the PA/PA. Attachment 8 is a sample PA/PA for providers to photocopy.

Obtaining prior authorization request forms

The PA/PA is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since it has a preprinted PA number on it.) To access the PA/PA and other Medicaid forms, follow these instructions:

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

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

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

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid.

* 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.

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
Revenue code conversion chart for nursing home services

(For claims and prior authorization requests submitted after HIPAA implementation)

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

Before HIPAA implementation		After HIPAA implementation		
Local level of care code	**Local level of care code description**	**Replaced by revenue code**	**Revenue code description**	**Required condition code**
20	Skilled nursing room/bed	0194	Subacute Care Level IV — Intensive Care: Extensive nursing and technical intervention.	
21	Intermediate care — room/bed	0193	Subacute Care Level III — Complex Care: Moderate to extensive nursing intervention.	
22	Personal care room/bed	0192	Subacute Care Level II — Comprehensive care: Moderate nursing intervention.	
23	Residential care room/bed	0191	Subacute Care Level I — Skilled Care: Minimal nursing intervention.	
25	Intensive skilled room/bed	0199	Other subacute care intensive treatment.	
26	DD1A — All developmentally disabled children under the age of 18 and adults of any age who require active treatment and whose health status is fragile, unstable, or relatively unstable.	0190	Subacute Care — General Classification + Disability.	A5
27	DD1B — All developmentally disabled children under the age of 18 and adults of any age who require active treatment and who exhibit behaviors of sufficient frequency, severity, or duration to cause a threat to health, safety, or welfare of themselves or others. These persons may manifest hyperactive behaviors; they may be security risks.	0194	Subacute Care Level IV — Intensive Care: Extensive nursing and technical intervention + Disability.	A5
28	DD2 — The DD2 describes an adult who requires active treatment to learn basic ADL and social skills. These persons have the learning capacity to perform some of these skills with staff intervention.	0193	Subacute Care Level III — Complex Care: Moderate to extensive nursing intervention + Disability.	A5
29	DD3 — The DD3 care level describes an adult who requires active treatment to learn a variety of skills in many areas, including, but not limited to, social skills, leisure skills, domestic, and vocational skills. These persons have the learning capacity to perform some of these skills independently and some with staff intervention.	0192	Subacute Care Level II — Comprehensive Care: Moderate nursing intervention + Disability.	A5

Before HIPAA implementation		After HIPAA implementation		
Local code	**Local code description**	**Replaced by revenue code**	**Revenue code description**	**Required condition code**
30	Skilled — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider.	
31	Immediate hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider.	
32	Personal — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider.	
33	Residential — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider.	
35	Intensive SNF — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider.	
36	DD1A — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
37	DD1B — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
38	DD2 — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
39	DD3 — Hospital bedhold	0185	Leave of Absence — Nursing Home (for Hospitalization). Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
40	Skilled therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider.	
41	Intermediate therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider.	
42	Personal therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider.	
43	Residential therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider.	

Before HIPAA implementation		After HIPAA implementation		
Local code	**Local code description**	**Replaced by revenue code**	**Revenue code description**	**Required condition code**
45	Intensive SNF — Therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider.	
46	DD1A — Therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
47	DD1B — Therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
48	DD2 — Therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
49	DD3 — Therapeutic leave	0183	Leave of Absence — Therapeutic Leave. Charges for holding a room while the patient is temporarily away from the provider + Disability.	A5
80	Brain injured	0199	Subacute Care — Other + Disability.	A5
81	Intensive brain injured	0199	Subacute Care — Other.	X0
M6	Non-covered vision services	0962	Professional fees — Opthalmology.	
M7	Non-covered dental services	0969	Professional fees — Other.	
M8	Other non-covered services	0999	Patient Convenience Items — Other.	
N2	Transportation — non-emergency	0960	Professional fees — General classification.	
N3	Laboratory	0300	Laboratory — General classification. Charges for the performance of diagnostic and routine clinical laboratory tests.	
N4	X-ray	0320	Radiology — Diagnostic — General classification. Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, and interpreting radiographs and flourographs.	
N6	Private room rate	0110	Room and Board — Private (Medical or General) — General classification. Routine service charges for single bed rooms.	
N7	Ventilator Care	0946	Other Therapeutic Services — Complex Medical Equipment — Routine. Charges for other therapeutic services not otherwise categorized.	
N9	AIDS/ARC	0940	Other Therapeutic Services — General Classification. Charges for other therapeutic services not otherwise categorized.	

ATTACHMENT 2
UB-92 (CMS 1450) claim form instructions for nursing home services

(For claims submitted after HIPAA implementation)

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

These instructions are for the completion of the UB-92 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card when initially 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.

Form Locator 1 — Provider Name, Address, and Telephone Number

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. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — ERO Assigned Number (not required)

Form Locator 3 — Patient Control No. (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 (R/S) Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. Bill numbers for nursing homes include the following:

211 = Inpatient Nursing Home — Admit through Discharge Claim
212 = Inpatient Nursing Home — Interim, first claim

213 = Inpatient Nursing Home — Interim, continuing claim
214 = Inpatient Nursing Home — Interim, last claim

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 1, 2003, would be 11/01/03). Include the date of discharge or death. Do not include Medicare coinsurance days.

Form Locator 7 — Cov D.

Enter the total number of days covered by the primary payer, as qualified by the payer organization. Do *not* include the day of discharge or death. Do not include Medicare coinsurance days.

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (required for crossover claims)

Enter the number of Medicare coinsurance days.

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient 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.

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date

Enter the admission date in the MM/DD/YY format (e.g., November 1, 2003, would be 11/01/03). The date of admission to the nursing home is the first date the recipient enters the facility as an inpatient for the current residency. (Current residency is not interrupted by bedhold days or changes in level of care or payer status.)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src

For bill type 211 and 212, enter the code indicating the source of this admission.

Code Structure for Source of Admission		
Code	**Title**	**Description**
1	Physician referral	The recipient was admitted to this facility by the recommendation of his or her personal physician.
2	Clinic referral	The recipient was admitted to this facility by the recommendation of this facility's clinic physician.
3	HMO referral	The recipient was admitted to this facility by the recommendation of an HMO physician.
4	Transfer from a hospital	The recipient was admitted to this facility as a hospital transfer from an acute care facility where the recipient was an inpatient.
5	Transfer from a skilled nursing facility	The recipient was admitted to this facility as a transfer from a skilled nursing facility where the recipient was an inpatient.
6	Transfer from another health facility	The recipient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities, and skilled nursing facility recipients that are at a nonskilled level of care.
7	Emergency room	The recipient was admitted to this facility by the recommendation of this facility's emergency room physician.
8	Court/law enforcement	The recipient was admitted to this facility by the direction of a court of law or by the request of a law enforcement agency representative.
9	Information not available	The means by which this recipient was admitted to this facility is not known.

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat

Enter the code indicating patient status as of the "Statement Covers Period" through date from Form Locator 6.

Code Structure for Patient Status	
Code	**Description**
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short-term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification.
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under care of a Home IV provider.
20	Expired.
30	Still patient.

Form Locator 23 — Medical Record No. (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the R/S Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locators 24-30 — Condition Codes (required, if applicable)

Enter the code identifying a condition related to this claim.

Condition Code Structure for Insurance Codes		
Code	**Title**	**Description**
01	Military service related	Medical condition incurred during military service.
02	Condition is employment related	Recipient alleges that medical condition is due to environment/events resulting from employment.
03	Patient covered by insurance not reflected here	Indicates that recipient/recipient's representative has stated that coverage may exist beyond that reflected on this bill.
05	Lien has been filed	Provider has filed legal claim for recovery of funds potentially due to a recipient as a result of legal action initiated by or on behalf of the recipient.
A5	Disability	Developmentally disabled.
X0		Intensive brain injury.

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)

Code Structure for Occurrence Codes and Dates		
Code	**Title**	**Description**
01	Auto accident	Code indicating the date of an auto accident.
02	No fault insurance involved — including auto accident/other	Code indicating the date of an accident including auto or other where state has applicable no-fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/tort liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/employment related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other accident	Code indicating the date of an accident not described by the above codes.
06	Crime victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.
Enter the revenue code which identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code "0001" on the line with the sum of all the charges. Do not include Medicare coinsurance days.

Form Locator 43 — Description
Enter the first date of service (DOS) billed in MMDDYY format followed by a dash. Then enter the last DOS being billed in MMDDYY format. Do *not* include the date of discharge or death. Do not include Medicare coinsurance insurance days.

Form Locator 44 — HCPCS / Rates (not required)

Form Locator 45 — Serv. Date (not required)

Form Locator 46 — Serv. Units
Enter the number of covered accommodations days or ancillary units of service for each line item. Do not count or include the day of discharge/death for accommodation codes. Do not include Medicare coinsurance days. The sum of the accommodation days must equal the billing period in Form Locator 43 and must equal the total days in Form Locator 7. For transportation services, enter the number of miles.

Form Locator 47 — Total Charges (by accommodation / ancillary code category)
Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, "statement covers period." Enter revenue code "0001" to report the sum of all charges in Form Locator 47.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer
Enter all health insurance payers here. For example, enter "T19" for Wisconsin Medicaid and/or the name of commercial health insurance. Enter "patient liability amount" to identify any patient liability.

Form Locator 51 A-C — Provider No.
Enter the number assigned to the provider by the payer indicated in Item 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C & P — Prior Payments (required, if applicable)
Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due
Enter the dollar amount of any patient liability.

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured's Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (required, if applicable)
Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF) for all services requiring PA (e.g., ventilator, Acquired Immune Deficiency Syndrome, head injury). 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. Do not attach the PA to the claim.

Form Locator 64 A-C — ESC (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.
Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" codes.

Form Locators 68-75 — Other Diag. Codes
Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 76 — Adm. Diag. Cd.
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Form Locator 80 — Principal Procedure Code and Date (not required)

Form Locator 81 — Other Procedure Code and Date (not required)

Form Locator 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number or license number and name.

Form Locator 83 a-b — Other Phys. ID (not required)

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial health insurance billing information

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

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Form Locator 84 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** line of Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 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.

Medicare information

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code 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 ("MMC") 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 the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-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 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).

Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85. 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.

Form Locator 86 — Date

Enter the date on which the claim is submitted to the payer.

ATTACHMENT 3

Sample UB-92 claim form for nursing homes billing straight Wisconsin Medicaid involving Medicare Part A Coinsurance Days claim

APPROVED OMB NO. 0938-0279

IM BILLING NURSING HOME 1 W WILLIAMS ST ANYTOWN, WI 55555 (555) 321-1234	2			3 PATIENT CONTROL NO. 12345					4 TYPE OF BILL 212
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 11/25/03	THROUGH 11/30/03	7 COV D. 6	8 N-C D.	9 C-I D.	10 L-R D.	11	

12 PATIENT NAME: RECIPIENT, IMA H.

13 PATIENT ADDRESS:

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 26	28	30	31
			06/21/03			4		30	99876					

	32 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a								A
b								B
								C

38

	39 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a				
b				
c				
d				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0193	112503 — 113003			6	999 99		
2								
3								
4	0001	TOTAL CHARGES				999 99		
5–23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	MED MEDICARE				0 00		
B	T19 MEDICAID	87654321					
C	PATIENT LIABILITY					99 99	

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			1234567890		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
1508	2800	2765			1508		

79 P.C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 87654321 IM ATTENDING PHYSICIAN

83 OTHER PHYS. ID

OTHER PHYS. ID

	84 REMARKS
a	
b	M-7
c	
d	

85 PROVIDER REPRESENTATIVE: X *Ima H. Provider* 86 DATE: 12/09/03

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 **OCR / Original**

ATTACHMENT 4

Sample UB-92 claim form for nursing homes billing standard Wisconsin Medicaid claim with Bedhold Days — Ancillaries (not a dual-entitlee)

APPROVED OMB NO. 0938-0279

IM BILLING NURSING HOME 1 W WILLIAMS ST ANYTOWN, WI 55555 (555) 321-1234	2	3 PATIENT CONTROL NO. 01234567890	4 TYPE OF BILL 212
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 11/01/03 THROUGH 11/30/03	7 COV D. 30 / 8 N-C D. / 9 C-I D. / 10 L-R D. / 11

12 PATIENT NAME: RECIPIENT, IMA H.

13 PATIENT ADDRESS:

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES	31
			06/21/03			4		30	99876	A5	

	32 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a								A
b								B
								C

38

	39 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a				
b				
c				
d				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0194	110103 — 110703			7	999 99		
2								
3	0185	110803 — 111203			5	999 99		
4								
5	0194	111303 — 113003			18	999 99		
6								
7	0001	TOTAL CHARGES				9999 99		
8–23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	T19 MEDICAID	87654321				99 99	
B	PATIENT LIABILITY						
C							

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			1234567890		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	1234567			
B				
C				

67 PRIN. DIAG. CD.	68 CODE	70 CODE	OTHER DIAG. CODES 72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
4280	78052	5640	7806		4280		

79 P.C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 87654321 (a) / IM ATTENDING PHYSICIAN (b)

83 OTHER PHYS. ID (a) (b)

OTHER PHYS. ID (a) (b)

84 REMARKS (a b c d)

85 PROVIDER REPRESENTATIVE: X *Ima H. Provider* — 86 DATE: 12/09/03

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 **OCR / Original**

ATTACHMENT 5
Prior Authorization Request Form (PA/RF)
Completion Instructions for nursing home services

(For prior authorization requests submitted after HIPAA implementation)

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

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

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

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

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

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

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

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

Element 2 — Telephone Number — Billing Provider

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

Element 3 — Processing Type

Enter 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.

134 — Acquired Immune Deficiency Syndrome (AIDS) Services (hospital and nursing home)
135 — Ventilator Service
999 — Other (use only if the requested category or service is not listed above)

Element 4 — Billing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

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

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

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

Element 8 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service requested.

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 requested, if applicable.

Element 14 — Requested Start Date
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 (not required)

Element 16 — Procedure Code
Enter the appropriate National Uniform Billing Committee (NUBC) revenue code for each service requested.

Element 17 — Modifiers (not required)

Element 18 — POS

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed.

POS	Description
31	Skilled Nursing Facility
32	Nursing Facility
54	Intermediate Care Facility/Mentally Retarded

Element 19 — Description of Service

Enter a written description corresponding to the appropriate NUBC revenue code for each service/procedure/item requested.

Element 20 — QR

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

Hospital and Nursing Home AIDS Services — number of days
Hospital and Nursing Home Ventilator Services — number of days

Element 21 — Charge

Enter the usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

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

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service 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 nursing home services

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

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

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number

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**	**(999) 123-4567** 4. Billing Provider's Medicaid Provider Number **12345678**	**135**

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	**09/23/72**	**Anytown Nursing Home** **609 Willow** **Anytown WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A.	☒ M ☐ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
518.83 — Chronic respiratory failure	**N/A**	**N/A**
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
V46.1 — Dependence on respirator	**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
	0946					**31**	**Ventilator dependent, $375.00/day**	**31**	**$11,625.00**

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**	**$11,625.00**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I. M. Requesting	**11/06/03**

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
Prior Authorization Physician Attachment (PA/PA) Completion Instructions

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

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

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

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

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

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

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

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

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient (Last, First, Middle Initial)
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

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

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the provider who would perform/provide the requested service/procedure.

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

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

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

SECTION III — SERVICE INFORMATION

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

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

ATTACHMENT 8
Prior Authorization Physician Attachment (PA/PA) (for photocopying)

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

(This page intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

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

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

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

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

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

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

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

SECTION I — RECIPIENT INFORMATION

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

3. Wisconsin Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

5. Performing Provider's Medicaid Number

6. Telephone Number — Performing Provider

7. Name — Ordering / Prescribing Physician

SECTION III — SERVICE INFORMATION

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

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

C. Supply justification for service or procedure requested.

D. SIGNATURE — Physician	Date Signed