

To:
Specialized
Medical Vehicle
Providers
HMOs and Other
Managed Care
Programs

Changes to local codes, paper claims, and prior authorization for specialized medical vehicle services in conjunction with HIPAA requirements

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for specialized medical vehicle (SMV) services, effective October 2003, in conjunction with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

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

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

Changes in conjunction with HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for specialized medical vehicle (SMV) services. These changes will be implemented in October 2003 in conjunction with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). While HIPAA and Wisconsin Medicaid will *not* require providers to conduct electronic transactions, Wisconsin Medicaid strongly encourages SMV providers to do so.

When HIPAA is implemented, Wisconsin Medicaid will require SMV providers who submit *electronic* transactions to use HIPAA-compliant transactions. For more information, refer to the frequently asked questions in the December 2002 *HIPAA inSight* (PHC 1920).

A future *Update* will notify providers of the specific implementation dates for the various HIPAA changes. These changes are *not* policy or coverage related (e.g., PA requirements, documentation requirements), but include:

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

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 codes to replace currently used Wisconsin Medicaid local codes for SMV services.

Allowable procedure codes

Wisconsin Medicaid will adopt Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace the following currently used local procedure codes for SMV providers:

- W9053-W9058 and W9090-W9091. These local codes will be replaced by HCPCS procedure code S0209 (wheelchair van, mileage, per mile).
 - ✓ Wisconsin Medicaid reimburses for “unloaded mileage” when the SMV travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient’s location.
 - ✓ When billing for mileage, providers should use exact mileage, including tenths of a mile (1.0 mile = 1.0 unit).
- W9095. This local code will be replaced by HCPCS procedure code A0170 (transportation ancillary: parking fees, tolls, other).
 - ✓ “Waiting time” occurs when an SMV provider waits for the recipient to return to the vehicle while the recipient receives medical services.
 - ✓ When billing for waiting time, providers must indicate units of time in fractions of an hour (1.0 hour = 1.0 unit) (e.g., 1 hour, 40 minutes = 1.7 units).
- W9096-W9097. These local codes will be replaced by HCPCS procedure code A0130 (non-emergency transportation: wheelchair van).
 - ✓ The base rate includes the first five miles of the trip.
 - ✓ When billing for SMV base rate, providers must indicate units as one base rate for the first five miles of the trip. The base rate should *only* be indicated as a unit of “1.”

- W9098. This local code will be replaced by HCPCS procedure code T2001 (non-emergency transportation; patient attendant/escort).
 - ✓ When billing for an additional attendant, providers must indicate one unit per trip with an additional attendant (1 trip = 1 unit).

Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers are required to use the appropriate HCPCS procedure code that describes the service performed.

Modifiers

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

- Local service-provided modifiers “TB,” “TC,” “TD,” “TE,” “TH,” “TI,” “TL,” “TM,” “TO,” “TR,” and “TS” have been eliminated. Providers will no longer need to include these modifiers on claim forms or on PA forms.
- National modifiers with local descriptions will replace the local trip modifiers “11”-“20.” Wisconsin Medicaid SMV providers will be required to use national modifiers “U1,” “U2,” “U3,” “U4,” “U5,” or “U6” to indicate the trip number. All procedure codes will require a trip modifier.
- Modifier “TK” (extra patient or passenger, non-ambulance) will be required on claims to indicate “multiple carry trips.” Providers will be required to use modifier “TK” when transporting two or more Medicaid recipients on the same trip.
- Modifier “TP” (medical transport, unloaded vehicle) will be required on claims to indicate unloaded mileage.

Providers will be required to use nationally recognized HCPCS modifiers in place of the local modifiers currently used by Wisconsin Medicaid.

Specialized medical vehicle providers will be required to submit all claims using the national *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code V63.0.

- Modifier “**HR**” (hospital discharge) will be required on claims to indicate transportation provided to a recipient following a hospital discharge.
- Modifier “**NR**” (nursing home discharge) will be required on claims to indicate transportation provided to a recipient following a nursing home discharge.
- Modifier “**TN**” (rural/outside providers’ customary service area) will be required on claims to indicate trips originating in a “rural” county, regardless of the number of miles the SMV travels in that trip. For Medicaid SMV services, a rural county is a county *other than* the following: Brown, Dane, Fond du Lac, Kenosha, La Crosse, Manitowoc, Milwaukee, Outagamie, Sheboygan, Racine, Rock, and Winnebago.
 - ✓ Wisconsin Medicaid requires PA for any one-way SMV trip originating in a rural county that is over 70 miles. If the trip originates in a nonrural county, PA is required for any one-way trip over 40 miles. Modifier “TN” will be used to determine which mileage limit applies to the claim during processing.

Refer to Attachment 2 for a listing of national HCPCS modifiers for SMV services. Refer to Attachment 1 for a listing of valid modifiers that may be used with each new procedure code.

Diagnosis codes

Specialized medical vehicle providers will be required to submit all claims using the national *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code V63.0. Any claim that has a diagnosis code other than V63.0 entered in Element 21 of the claim form will be denied.

All other local diagnosis codes will be eliminated and will no longer be valid on claim forms or PA

forms after HIPAA implementation. Codes eliminated are as follows:

- Local county codes.
- Local description codes.
- Local generic diagnosis code 00025.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 3 for a list of allowable POS codes for SMV services.

Type of service codes

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

Coverage for specialized medical vehicle services

Medicaid coverage and documentation requirements for SMV providers will remain unchanged. Refer to the Specialized Medical Vehicle Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified SMV providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 4 for the revised instructions. Attachments 5-8 contain two samples of claims for SMV services that reflect 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 instructions for the CMS 1500 paper claim form include the following:

- Only ICD-9-CM diagnosis code V63.0 may be entered for SMV services (Element 21).
- 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).

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, SMV 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 9. A sample PA/RF is in Attachment 10.

Allowable procedure code for prior authorization

Generic procedure code 00025 will be eliminated. Providers will be required to use HCPCS procedure code S0209 in Element 16 of the PA/RF.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

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

Prior authorization attachments

The Prior Authorization/Specialized Medical Vehicle Attachment (PA/SMVA), HCF 11028,

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 sample PA/SMVA that may be photocopied by providers.

STAT-PA

A future *Update* will explain changes made to Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) as a result of HIPAA.

Obtaining prior authorization request forms

The PA/SMVA 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/SMVA 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.

* 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.

With the implementation of HIPAA, SMV providers submitting PA requests on paper will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03.

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

To request paper copies of the PA/SMVA 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.

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/admsimp/ — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- www.dhfs.state.wi.us/hipaa/ — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

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

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

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

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

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

ATTACHMENT 1

Procedure code conversion chart for specialized medical vehicle services

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

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

Before HIPAA implementation		After HIPAA implementation						
Local procedure code	Procedure code description	Replaced by HCPCS ¹ procedure code	HCPCS procedure code description	Valid modifiers for procedure code				
				Trip modifiers	Discharge modifiers	Unloaded mileage modifier	Multiple carry modifier	Rural county trip modifier
W9053	SMV unloaded mileage (20.1-30 miles)	S0209	Wheelchair van, mileage, per mile [1.0 unit = 1.0 mile] ²	U1, U2, U3, U4, U5, U6		TP		
W9054	SMV unloaded mileage (30.1-45 miles)							
W9055	SMV unloaded mileage (45.1-60 miles)							
W9056	SMV unloaded mileage (60.1-75 miles)							
W9057	SMV unloaded mileage (75.1-90 miles)							
W9058	SMV unloaded mileage (90.1+ miles)							
W9090	SMV mileage	S0209	Wheelchair van, mileage, per mile [1.0 unit = 1.0 mile] ²	U1, U2, U3, U4, U5, U6	HR, NR			TN
W9091	Multiple carry SMV mileage	S0209	Wheelchair van, mileage, per mile [1.0 unit = 1.0 mile] ²	U1, U2, U3, U4, U5, U6	HR, NR		TK	TN
W9095	SMV waiting time per hour	A0170	Transportation ancillary: parking fees, tolls, other [1.0 unit = 1.0 hour] ³	U1, U2, U3, U4, U5, U6				
W9096	SMV base rate up to 5 miles	A0130	Nonemergency transportation: wheelchair van [1 unit = 1 base rate includes 5 miles]	U1, U2, U3, U4, U5, U6	HR, NR			
W9097	Multiple carry SMV base rate up to 5 miles	A0130	Nonemergency transportation: wheelchair van [1 unit = 1 base rate includes 5 miles]	U1, U2, U3, U4, U5, U6	HR, NR		TK	
W9098	SMV second attendant per trip	T2001	Non-emergency transportation: patient attendant/escort [1 unit = 1 trip]	U1, U2, U3, U4, U5, U6				

¹HCPCS = Healthcare Common Procedure Coding System.

²Use exact mileage, including tenths of a mile.

³Include time in fractions of an hour.

ATTACHMENT 2

Modifiers for specialized medical vehicle services

The following table lists the nationally recognized modifiers that providers will be required to use when submitting claims for specialized medical vehicle (SMV) 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).

Trip modifier chart

National modifier	Local Medicaid modifier description for SMV services
U1	First or only trip
U2	Second trip
U3	Third trip
U4	Fourth trip
U5	Fifth trip
U6	Sixth trip

Additional modifiers for specialized medical vehicle services

Modifier	National modifier description
TK	Extra patient or passenger, non-ambulance
TP	Medical transport, unloaded vehicle
HR	Hospital discharge
NR	Nursing home discharge
TN	Rural/outside providers' customary service area

ATTACHMENT 3

Place of service codes for specialized medical vehicle services

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

POS code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 4

CMS 1500 claim form instructions for specialized medical vehicle services

(For claims submitted after HIPAA implementation.)

Use the following claim form completion instructions, **not** the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

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

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "A" in the Medicaid check box for the service billed.

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 (not required)

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number (not required)

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

Wisconsin Medicaid requires this element to be completed for all specialized medical vehicle (SMV) services, except when the transportation is the result of a nursing home or hospital discharge. Enter the referring/prescribing 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. The referring provider is the medical practitioner who signed the Specialized Medical Vehicle Transportation Physician Certification form documenting the recipient's need for SMV transportation.

Nursing Home or Hospital Discharge

Specialized medical vehicle claims for transportation of a recipient due to a nursing home or hospital discharge do not require a referring physician's UPIN or provider number. Element 17 is left blank in this situation.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the appropriate diagnosis code for the services provided.

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 of the recipient's destinations. Refer to Attachment 3 of this *Wisconsin Medicaid and BadgerCare Update* for a list of SMV 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" corresponding to the diagnosis code listed in Element 21.

Element 24F — \$ Charges

Enter the total charge for each line item. Providers are 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., 2.3 units).

Element 24H — EPSDT/Family Plan (not required)**Element 24I — EMG (not required)****Element 24J — COB (not required)****Element 24K — Reserved for Local Use**

Any information entered in this element may cause claim denial.

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 (not required)**Element 30 — Balance Due**

Enter the same amount as is indicated 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 services are provided to a recipient who resides in a nursing home (POS code “31” or “32”), indicate the nursing home’s eight-digit 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, city, state, and Zip code. At the bottom of Element 33, enter the billing provider’s eight-digit Medicaid provider number.

ATTACHMENT 5

Sample CMS 1500 claim form: two trips with unloaded mileage and waiting time

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, I m A.					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>							
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>							
CITY Anytown			STATE WI		7. INSURED'S ADDRESS (No., Street)			CITY STATE				
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					
9a. OTHER INSURED'S POLICY OR GROUP NUMBER		9b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			9c. EMPLOYER'S NAME OR SCHOOL NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Provider					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V63.0					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER							
24. 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/HCP/CS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1		11		S0209 U1 TP		1	XXX XX	4.0				
2		11		A0130 U1		1	XXX XX	1.0				
3		11		S0209 U1		1	XXX XX	15.0				
4		11		A0170 U1		1	XXX XX	2.0				
5		12		S0209 U2		1	XXX XX	20.0				
6												
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$		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>J.M. Authorized</i> MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321				
SIGNED _____ DATE _____					PIN# _____ GRP# _____							

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

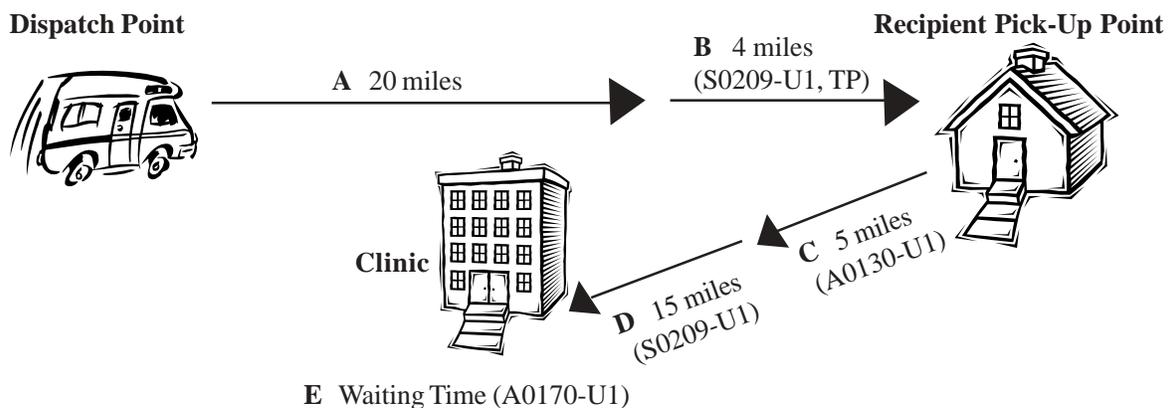
APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 6

Illustration of two trips with unloaded mileage and waiting time

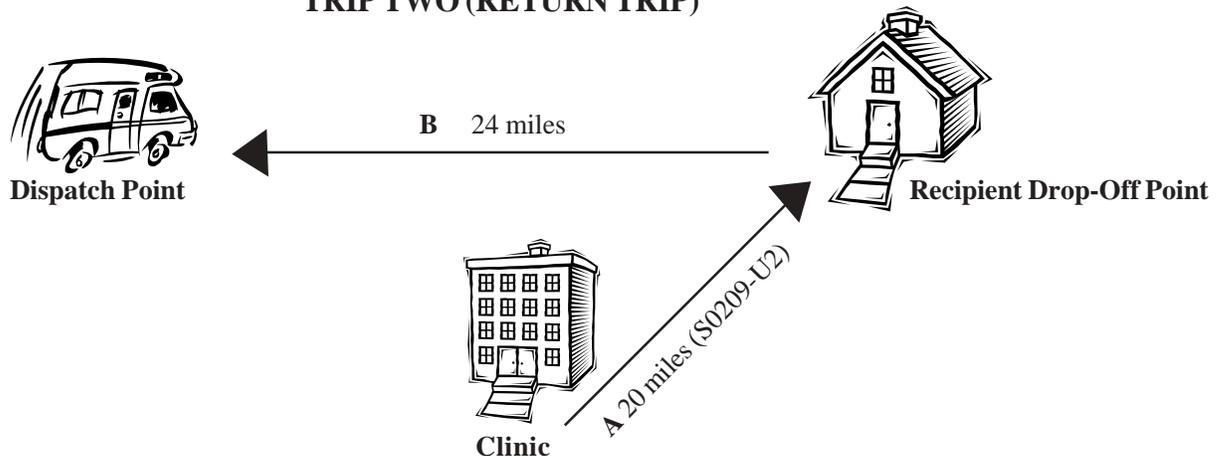
The following is an example of a trip that includes unloaded mileage and waiting time. “Unloaded mileage” is the distance traveled to pick up the recipient for transport to or from Medicaid-covered services. “Waiting time” refers to time spent by the specialized medical vehicle (SMV) provider waiting for the recipient to return to the vehicle while the recipient receives medical services.

TRIP ONE WITH WAITING TIME



- A** Van begins travel of first 20 miles to recipient pick-up point — no unloaded mileage.
- B** Van completes final four miles of travel to recipient pick-up point (S0209-U1, TP). Unloaded mileage applies because distance is 24 miles. Wisconsin Medicaid reimburses for unloaded mileage when the SMV travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient’s location.
- C** Van picks up recipient and travels to clinic; base rate (A0130-U1) includes first five miles.
- D** Remaining 15 miles to clinic count as mileage (S0209-U1).
- E** Van waits for recipient at clinic for two hours — counts as waiting time (A0170-U1).

TRIP TWO (RETURN TRIP)



- A** Van transports recipient to home (drop-off point) — base rate not billable because waiting time is billed. Billed as mileage (S0209-U2).
- B** Van returns to dispatch point empty. Unloaded mileage not allowed.

ATTACHMENT 7

Sample CMS 1500 claim form: one trip originating in a rural county with hospital discharge

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, I m A.					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>							
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>							
CITY Anytown			STATE WI		7. INSURED'S ADDRESS (No., Street)			CITY STATE				
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (INCLUDE AREA CODE)		STATE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO							
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN							
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
1. V63.0					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
2. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
3. _____					23. PRIOR AUTHORIZATION NUMBER 1234567							
4. _____					24. PROCEDURE(S) OF SERVICE, PLACE OF SERVICE, TYPE OF SERVICE, PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER, DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSDT Family Plan, EMG, COB, RESERVED FOR LOCAL USE							
1. MM DD YY		B 12	C	D A0130 U1 HR		E 1	F XXX XX	G 1.0	H	I	J	K
2. MM DD YY		B 12	C	D S0209 U1 HR TN		E 1	F XXX XX	G 73.0	H	I	J	K
3.		B	C	D		E	F	G	H	I	J	K
4.		B	C	D		E	F	G	H	I	J	K
5.		B	C	D		E	F	G	H	I	J	K
6.		B	C	D		E	F	G	H	I	J	K
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$		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>J.M. Authorized</i> 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. Billing 1 W. Williams Anytown, WI 55555 PIN# _____ GRP# _____					87654321							

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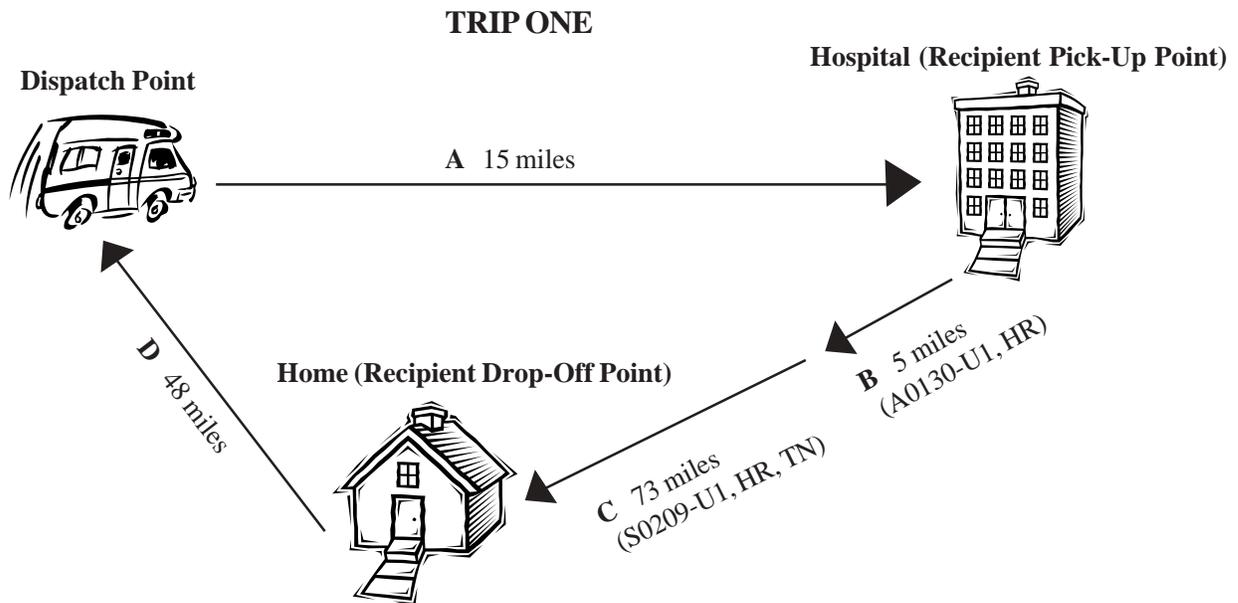
PLEASE PRINT OR TYPE

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

Illustration of one trip originating in a rural county with hospital discharge

The following is an example of a trip originating in a rural county that includes a recipient's hospital discharge.



- A** Van travels to recipient pick-up point — no unloaded mileage because distance is 15 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.
- B** Van picks up discharged recipient at hospital; base rate (A0130-U1, HR) includes first five miles.
- C** Remaining 73 miles to recipient's home count as mileage. Any trip originating in a rural county must use modifier "TN" (S0209-U1, HR, TN).
- D** Van returns to base empty. Unloaded mileage not allowed.

ATTACHMENT 9

Prior Authorization Request Form (PA/RF)

Completion Instructions for specialized medical vehicle 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/Specialized Medical Vehicle Attachment (PA/SMVA), 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 three-digit processing type 999. The processing type is a three-digit code used to identify a category of service requested.

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 *International Classification of Diseases, Ninth Edition, Clinical Modification* diagnosis code V63.0.

Element 11 — Start Date — SOI (not required)**Element 12 — First Date of Treatment — SOI (not required)****Element 13 — Diagnosis — Secondary Code and Description (not required)****Element 14 — Requested Start Date**

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 Healthcare Common Procedure Coding System procedure code S0209 for each service requested.

Element 17 — Modifiers (not required)**Element 18 — POS**

Enter the appropriate place of service code designating where the requested service would be provided.

Element 19 — Description of Service

When requesting PA for specialized medical vehicle (SMV) services/mileage, enter the written description “SMV mileage.”

Element 20 — QR

Enter the number of *calendar days* ordered on the prescription by the referring health care provider. For example, if the medical provider indicates the length of time in weeks, multiply the weeks by seven and enter the number of days. If the provider indicates the time in months, multiply the months by 30 and enter the number of days.

Element 21 — Charge (not required)**Element 22 — Total Charges (not required)****Element 23 — Signature — Requesting Provider**

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

Element 24 — Date Signed

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

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

ATTACHMENT 10

Sample Prior Authorization Request Form (PA/RF) for specialized medical vehicle 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) I.M. Provider 1 W Williams Anytown WI 55555		2. Telephone Number — Billing Provider (999) 123-4567	3. Processing Type 999			
		4. Billing Provider's Medicaid Provider Number 12345678				
SECTION II — RECIPIENT INFORMATION						
5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) 11/08/71	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown WI 55555				
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F				
SECTION III — DIAGNOSIS / TREATMENT INFORMATION						
10. Diagnosis — Primary Code and Description V63.0		11. Start Date — SOI	12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description		14. Requested Start Date 11/01/03				
15. Performing Provider Number	16. Procedure Code S0209	17. Modifiers 1 2 3 4	18. POS 11	19. Description of Service SMV Mileage	20. QR 60	21. Charge XXX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.						
22. Total Charges XXX.XX						
23. SIGNATURE — Requesting Provider <i>I. M. Requesting</i>				24. Date Signed 08/04/03		
FOR MEDICAID USE		Procedure(s) Authorized:		Quantity Authorized:		
<input type="checkbox"/> Approved		_____		_____		
		Grant Date		Expiration Date		
<input type="checkbox"/> Modified — Reason:		_____				
<input type="checkbox"/> Denied — Reason:		_____				
<input type="checkbox"/> Returned — Reason:		_____				
SIGNATURE — Consultant / Analyst				Date Signed		

ATTACHMENT 11
Prior Authorization / Specialized Medical Vehicle
Attachment (PA/SMVA)
(for photocopying)

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

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WISCONSIN MEDICAID PRIOR AUTHORIZATION / SPECIALIZED MEDICAL VEHICLE ATTACHMENT (PA/SMVA)

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.

Attach the completed Prior Authorization/Specialized Medicaid Vehicle Attachment (PA/SMVA) 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).

Provision of the information requested on this form is mandatory. However, the use of this version of the form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

SECTION I — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial)

Age — Recipient

Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

Name — Performing Provider

Telephone Number — Performing Provider

Performing Provider's Medicaid Provider Number

A. Do you have a current Physician Certification, signed by a physician, physician assistant, nurse midwife, or nurse practitioner documenting the recipient's need for specialized medical vehicle (SMV) transportation on file for this recipient?

Yes No

B. Attach a copy of the prescription for trips that exceed the SMV mileage limit signed and dated by a physician, physician assistant, nurse midwife, nurse practitioner, dentist, optometrist/optician, chiropractor, podiatrist, HealthCheck agency, or family planning clinic.

SIGNATURE — Requesting Provider

Date Signed
