wisconsin Medicaid update and BadgerCare

July 2003 ● No. 2003-69
PHC 1003

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Personal Care Agencies

HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for personal care 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 personal care 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 personal care 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). These changes include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising UB-92 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. 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 personal care services.

Allowable procedure codes

Wisconsin Medicaid will adopt Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology* (CPT) procedure codes to replace currently used Wisconsin Medicaid local procedure codes

(W9900, W9902, W9903, W9906) for personal care services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers will be required to use the appropriate CPT or HCPCS procedure code that describes the service performed.

The following specific changes will be made regarding procedure codes:

- Procedure codes W9900 and W9903 are being replaced by HCPCS procedure code T1019.
- Procedure code W9902 is being replaced by T1019 and a modifier.
- Procedure code W9906 is being replaced by CPT code 99509 and a modifier. Use procedure code 99509 for supervisory visits by an RN or therapist.

Modifiers

Providers will be required to use nationally recognized modifiers that are state defined for personal care services. Refer to Attachment 1 for the new modifiers and the procedure codes to which they apply.

Revenue codes are required

Wisconsin Medicaid will adopt nationally recognized four-digit revenue codes for personal care services. Providers will be required to use a revenue code with a preceding "0" before a three-digit revenue code when submitting claims for personal care services. Refer to Attachment 2 for a list of examples of revenue codes. For the most current and complete list of revenue codes, contact the National Hospital Association National Uniform Billing Code Committee. Providers should use the appropriate revenue code that best describes the service performed.

Time units

One unit of service will be equal to 15 minutes for procedure code T1019. Refer to Attachment 3 for new rounding guidelines.

Coverage for personal care services

Medicaid coverage and documentation requirements for personal care services will remain unchanged. Refer to the Personal Care Handbook and *Updates* for complete Medicaid policies and procedures.

One unit of service will be equal to 15 minutes for procedure code T1019. Refer to Attachment 3 for new rounding guidelines.

Revision of UB-92 paper claim instructions

With the implementation of HIPAA, Medicaid-certified personal care providers 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 4 for the revised instructions. Attachment 5 is a sample of a claim for personal care services that reflects the changes to the billing instructions.

Note: In some instances, paper claim instructions are 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:

- Spenddown amount (value code "22") should no longer be entered in Form Locators 39-41 a-d. Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

- Revenue code required (Form Locator 42). Attachment 2 is a sample list of National Uniform Billing Code revenue codes.
- Medicare and other insurance disclaimer codes revised (Form Locator 84).

Revision of prior authorization request forms and instructions

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

Providers must continue to send applicable attachments (such as the physician's orders or the Wisconsin Medicaid Home Care Assessment Form) with all requests as indicated in the Prior Authorization section of the Personal Care Handbook and *Updates*.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Requested start date field added (Element 14).
- Space added for additional modifiers (Element 17).
- Nationally recognized two-digit POS codes will replace the one-digit POS codes used currently by Wisconsin Medicaid on PA requests. Refer to Element 18 of the instructions for a list of allowable POS codes for personal care services.
- Type of service codes will no longer be required on PA requests.

Prior Authorization Amendment Request revised

The Prior Authorization Amendment Request, HCF 11042, dated 06/03, has been revised. The basic information requested on the form has not changed; only the format of the form has changed. Refer to Attachment 8 for a copy of the completion instructions for the amendment request form. Attachment 9 is a copy of the Prior Authorization Amendment Request for providers to photocopy.

Prior authorization attachments

Providers must continue to send applicable attachments (such as the physician's orders or the Wisconsin Medicaid Home Care Assessment Form) with all PA requests as indicated in the Prior Authorization section of the Personal Care Handbook and *Updates*. Refer to the Prior Authorization section of the Personal Care Handbook for samples of the applicable forms which may be photocopied.

Obtaining prior authorization request forms

The Prior Authorization Amendment Request form is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it.) To access the Amendment Request Form 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 forms, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

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

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

General HIPAA information

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

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

Information regarding Medicaid HMOs

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

---

* The 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.

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 personal care services

The following table lists the nationally recognized procedure codes that providers will be required to use when submitting claims for personal care 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 and description	**National procedure code and description (Limited to current Wisconsin Medicaid covered service)**	**Modifier**
W9900 Personal care by personal care-only agency	**T1019** Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	None
W9903 Personal care — Home health agency	**T1019** Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	None
W9902 Personal care travel time	**T1019** Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	**U3** Travel time
W9906 Registered nurse supervisory visit — Routine visit	**99509** Home visit for assistance with activities of daily living and personal care (per visit)	**TD** Registered Nurse

ATTACHMENT 2
Examples of National Uniform Billing Code revenue codes

Providers are required to use the appropriate revenue codes on the UB-92 claim form for personal care services. The codes listed below are examples of codes that might be used.

Code	Service description
0550	Skilled Nursing
0551	Skilled Nursing Visit
0559	Skilled Nursing Hourly Charge
0570	Personal Care

For the most current and complete list of revenue codes, contact the American Hospital Association National Uniform Billing Code (NUBC) Committee at:

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/*.

ATTACHMENT 3
Rounding guidelines for personal care services

Time units are calculated based on rounding accumulated minutes of service for each day. The following chart illustrates the rules of rounding and gives the appropriate billing unit.

Accumulated time	Unit(s) billed
1-22 minutes	1.0
23-37 minutes	2.0
38-52 minutes	3.0
53-67 minutes	4.0
68-82 minutes	5.0
83-97 minutes	6.0
98-112 minutes	7.0
113-127 minutes	8.0
Etc.	9.0+

ATTACHMENT 4
UB-92 (CMS 1450) claim form instructions for personal care services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the claim 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 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 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. Minimum requirement is the provider's name, city, state and ZIP code. The name in Form Locator 1 should correspond to the provider number in Form Locator 51.

Form Locator 2 — Unlabeled Field (not required)

Form Locator 3 — Patient Control No. (not required)

The provider may enter the patient's internal office account number. This number will appear on the Wisconsin Medicaid 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 code indicating the specific type of claim. The first digit identifies the type of facility. The second digit classifies the type of care. Personal care/home health providers are required to use bill type 33X. The third digit ("X") indicates the billing frequency and should be assigned as follows (331, 332, 333, or 334):

1 = Admit through discharge claim
2 = Interim — first claim
3 = Interim — continuing claim
4 = Interim — final claim

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

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Cov D. (not required)

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

Form Locator 9 — C-I D. (not required)

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 (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src (not required)

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

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)

If appropriate, enter a code to identify conditions relating to this claim that may affect payer processing. Refer to the UB-92 Billing Manual for codes.

Form Locator 31 — Unlabeled Field (not required)

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

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates are required to be printed in the MMDDYY format. Refer to the UB-92 Billing Manual for codes.

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 appropriate four-digit revenue code for the procedure code indicated in Form Locator 44. Enter revenue code "0001" on the line with the sum of all the charges. Refer to the UB-92 Billing Manual for codes.

Form Locator 43 — Description

Enter the date of service (DOS) in the MMDDYY format either in this form locator or in Form Locator 45.

When series billing (i.e., billing from two to four DOS on the same line), indicate the DOS in the following format: MMDDYY, MMDD, MMDD, MMDD. Indicate the dates in order of occurrence from the first to the last of the month.

Providers may enter up to four DOS for each revenue and procedure code if all the following conditions are met:

- All DOS are in the same calendar month.
- All DOS are listed in order of occurrence from the first to the last of the month.
- All procedure codes are identical.
- All procedure modifiers are identical.
- All charges are identical.

- All quantities billed for each DOS are identical.

On paper claims, no more than 23 lines may be submitted on a single claim, including the "total charges" line.

> *Note*: Wisconsin Medicaid encourages providers to enter only one DOS per line. Although series billing (entering multiple DOS on the same line) remains an option, providers may find that meeting the conditions limits the convenience of utilizing this method.

Form Locator 44 — HCPCS/Rates

Enter the appropriate five-digit procedure code and the appropriate modifier.

Form Locator 45 — Serv. Date

Enter the DOS in the MMDDYY format either in this item or in Form Locator 43. Do not indicate multiple DOS in this form locator. Multiple DOS are required to be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of covered accommodations days, ancillary units of service, or visits, where appropriate.

Form Locator 47 — Total Charges

Enter the usual and customary charges pertaining to the related procedure code for the current billing period as entered in Form Locator 43 "Description" or Form Locator 45 "Serv. Date." 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 private insurance.

Form Locator 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Form Locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond to 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 (not required)

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). Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per 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) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis.

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. 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. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis.

Form Locator 76 — Adm. Diag. Cd. (not required)

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 (not required)

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 billing Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

When the recipient has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When 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 commercial insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes ***must*** be indicated in 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 submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Form Locator 85 — Provider Representative

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

Note: The signature may be a computer-printed or typed name or a signature stamp.

Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

ATTACHMENT 5
Sample UB-92 claim form for personal care services

APPROVED OMB NO. 0938-0279

IM BILLING PROVIDER 1 W. WILSON ANYTOWN, WI 55555 (555) 321-1234	2	3 PATIENT CONTROL NO. JED 1234	4 TYPE OF BILL 4

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS
RECIPIENT, IM A.	

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 26	28	30	31
									03 7654321					

	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				a
	b				b
	c				c
	d				d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2	0570	111003, 1113, 1125, 1130	T1019		16.0	XXXX		
3	0570	111003, 1113, 1125, 1130	T1019 U3		8.0	XXXX		
4	0550	113003	99509 TD		1.0	XXXX		
5								
6	0001	TOTAL				XXXXX		
7–23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
A	XYZ INSURANCE						
B	T19 MEDICAID	87654321					
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					
B			1234567890		
C					

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

67 PRIN. DIAG. CD	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
5750							

79 P.C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE		82 ATTENDING PHYS. ID	
							a
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE	b
						83 OTHER PHYS. ID	a
							b
						OTHER PHYS. ID	a
							b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b	OI-D		
c			
d		X *Ima H. Provider*	110103

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

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

ATTACHMENT 6
Prior Authorization Request Form (PA/RF) Completion Instructions for personal care services

(For prior authorizations submitted after HIPAA implementation)

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

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

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

Providers may submit PA requests, along with all applicable service-specific attachments including the Wisconsin Medicaid Home Care Assessment Form or Update Form and a copy of the physician's orders, by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

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

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

Note: Wisconsin Medicaid accepts PA requests with a maximum of 12 details per PA number. The Wisconsin Medicaid PA/RF has space for five items. If a provider's PA request requires more than five items to be listed, the provider may continue the PA request on a second and third PA/RF. When submitting a PA request with multiple pages, indicate the page number and total number of pages for the PA/RF in the upper right hand corner (e.g., "page 1 of 2" and "page 2 of 2"). On the form(s) used for page 2 and, if appropriate, page 3, cross out the seven-digit PA number and write the PA number from the first form. Refer to instructions for Elements 16 and 22 for more information.

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

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

Element 2 — Telephone Number — Billing Provider

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

Element 3 — Processing Type
Enter processing type "120" for personal care services by a dually certified home health/personal care agency and "121" for services by a personal care-only agency. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

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

SECTION II — RECIPIENT INFORMATION

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

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

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

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

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

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

Note: If the provider needs additional spaces for Elements 16-21 for the PA request, the provider may complete additional PA/RF(s). The provider needs to cross out the preprinted PA number on the additional PA/RFs and write in the preprinted PA number from the first PA/RF. The PA/RFs should be identified, for example, as "page 1 of 2" and "page 2 of 2."

Element 17 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed in Attachment 1.

Element 18 — POS
Enter the appropriate place of service (POS) code designating where the requested service/procedure would be provided/performed/dispensed.

POS	Description
12	Home
34	Hospice

Element 19 — Description of Service
Enter a written description corresponding to the HealthCare Common Procedure Coding System procedure code for each service/procedure/item requested.

When requesting personal care services, indicate the number of units per week multiplied by the total number of weeks being requested. The total number of units requested on the PA/RF must be equivalent to the total number of hours ordered by the physician (4 units = 1 hour). If requesting travel time, enter this as a separate item using procedure code T1019 and modifier U3. Instructions for the physician's orders and the Wisconsin Medicaid Home Care Assessment Form are *not* changing.

If sharing a case with another provider, enter "shared case with (name of other provider)" and include a statement that the total number of units of all providers will not exceed the combined and total number of units ordered on the plan of care.

Element 20 — QR
Enter the appropriate quantity requested in units for the procedure code listed. To calculate total quantity requested, multiply the number of hours per week by the number of units per hour (4 units = 1 hour). Multiply that number by the number of weeks requested (e.g., hours/week x 4 units/hour x number of weeks). For example, 14 hours/week x 4 units/hour x 53 weeks = 2968 units.

Element 21 — Charge
Enter your usual and customary charge for each procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each procedure requested. Enter that total amount in this element.

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

Element 22 — Total Charge
Enter the anticipated total charge for this request. If the provider completed a multiple-page PA/RF, the total charges should be indicated on Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 should refer to the last page (for example, "SEE PAGE TWO.")

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting this service/procedure 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 7
Sample Prior Authorization Request Form (PA/RF) for personal care services

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

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

WISCONSIN MEDICAID

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **10 W. Williams** **Anytown, WI 55555**	**(555) 123-4567** 4. Billing Provider's Medicaid Provider Number **87654321**	**121**

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	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
401.9 — hypertension NOS		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
250.0 — diabetes II (NIDDM)		

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	T1019					**12**	**Personal care services** **56 units/wk x 53 wks**	**2,968**	**XXX.XX**
	T1019	**U3**				**12**	**Personal care travel time** **4 units/wk x 53 wks**	**212**	**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**	**X,XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Requesting	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized: Quantity Authorized:

❑ Approved _____ Grant Date _____ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 8
Prior Authorization Amendment Request Completion Instructions

(A copy of the "Prior Authorization Amendment Request Completion Instructions" is located on the following pages.)

[This page intentionally left blank.]

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable 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 Amendment Request to the Prior Authorization Request Form (PA/RF) and physician's orders (within 90 days of the dated signature) 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 that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Today's Date
Enter today's date in MM/DD/YYYY format.

Element 2 — Previous Prior Authorization Number
Enter the seven-digit PA request number from the PA/RF to be amended. The request number is located in the top right section of the PA/RF.

Element 3 — Name — Recipient
Enter the recipient's name as indicated in Element 8 of the PA/RF, including recipient's last and first name and middle initial.

Element 4 — Recipient Medicaid Identification No.
Enter the ten-digit recipient Medicaid identification number as indicated in Element 5 of the PA/RF.

SECTION II — PROVIDER INFORMATION

Element 5 — Name — Billing Provider
Enter the billing provider's name as indicated in Element 1 of the PA/RF.

Element 6 — Billing Provider's Medicaid Provider No.
Enter the eight-digit billing provider's Medicaid provider number as indicated in Element 4 of the PA/RF.

Element 7 — Address — Billing Provider
Enter the billing provider's address (include street, city, state, and Zip code) as indicated in Element 1 of the PA/RF.

Element 8 — Amendment Effective Dates
Enter the dates that the requested amendment should start and end.

SECTION III — AMENDMENT INFORMATION

Element 9
Enter the reasons for requesting additional service(s) for the recipient.

Element 10
Enter the appropriate procedure code and hours per day and days per week, multiplied by the number of weeks for each service.

Element 11 — Signature — Requesting Provider
Enter the signature of the provider requesting this amendment.

Element 12 — Date Signed
Enter the month, day, and year this amendment was signed (in MM/DD/YYYY format).

ATTACHMENT 9
Prior Authorization Amendment Request (for photocopying)

(A copy of the "Prior Authorization Amendment Request" [for photocopying] is located on the following pages.)

[This page intentionally left blank.]

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Amendment Request Completion Instructions (HCF 11042A).

SECTION I — RECIPIENT INFORMATION

1. Today's Date	2. Previous Prior Authorization Number
3. Name — Recipient (Last, First, Middle Initial)	4. Recipient Medicaid Identification No.

SECTION II — PROVIDER INFORMATION

5. Name — Billing Provider	6. Billing Provider's Medicaid Provider No.
7. Address — Billing Provider (Street, City, State, ZIP Code)	8. Amendment Effective Dates

SECTION III — AMENDMENT INFORMATION

9. List reasons for Amendment Request

10. Indicate procedure(s) to be amended by hours per day and days per week, multiplied by the number of weeks.

Registered Nurse _____

Licensed Practical Nurse _____

Home Health Aide _____

Physical Therapist _____

Occupational Therapist _____

Speech-Language Pathologist _____

Personal Care Worker _____

Other _____

11. **SIGNATURE** — Requesting Provider	12. Date Signed