

To:  
Nurses in  
Independent  
Practice  
HMOs and Other  
Managed Care  
Programs

## Changes to local codes, paper claims, and prior authorization for private duty nursing and respiratory care services of nurses in independent practice as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for private duty nursing (PDN) and respiratory care services (RCS), 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.
- Conversion from CMS 1500 paper claim instructions to UB-92 (CMS 1450) paper claim instructions.
- Revising Medicaid PA request forms and instructions.

A separate *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 nurses in independent practice (NIP) providing private duty nursing (PDN) and respiratory care services (RCS). These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and

Accountability Act of 1996 (HIPAA). A separate *Update* will notify providers of the specific effective dates for the various changes. These changes are *not* policy or coverage related (e.g., PA requirements, documentation requirements), but include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Conversion from CMS 1500 paper claim instructions to UB-92 paper claim instructions.
- Revising PA request forms and instructions.

*Note:* Use of the national codes that will replace Wisconsin Medicaid local codes, new paper claim instructions, or revised PA forms and instructions prior to implementation dates may result in claim denials and returned PA requests. Specific implementation dates will be published in a future *Update*.

### Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for NIP services.

### *Allowable procedure codes*

Wisconsin Medicaid will adopt nationally recognized Healthcare Common Procedure Coding System (HCPCS) procedure codes S9124 and S9123 to replace PDN local procedure codes W9045 and W9046, respectively. Respiratory care services local procedure codes W9041, W9042, W9967 and W9968 will all be replaced by *Current Procedural Terminology* (CPT) procedure code 99504. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers must use the appropriate HCPCS/CPT procedure code that describes the service performed.

### *Modifiers*

All NIP providers will be required to use nationally recognized modifiers with procedure codes.

Both PDN and RCS providers will be required to use state-defined start-of-shift modifiers on claims using the following guidelines:

- Valid start-of-shift modifiers are “UJ,” “UF,” “UG,” and “UH.”
- Choose the start-of-shift modifier that most closely represents the time each shift began. For each day, enter the modifiers in the order of occurrence.
- For those shift hours that cross midnight, use the modifier “UJ” with the hours claimed for the second date in a shift. Refer to the UB-92 claim example in Attachment 5 for an example of a claim for a shift whose hours cross midnight.
- A nurse will not be able to enter more than four modifiers for each day.

*Note:* NIP providers should not indicate a start-of-shift modifier on PA requests.

In addition, RCS providers will be required to use one of two nationally recognized modifiers with CPT procedure code 99504 to

indicate their professional status. A registered nurse will indicate modifier “TD,” and a licensed practical nurse will indicate modifier “TE.” Providers must include these modifiers on both claims and PA requests.

Registered nurses providing RCS reimbursable case coordination services will be required to indicate both modifier “U1” and a start-of-shift modifier with CPT procedure code 99504. Providers must include modifier “U1” on both claims and PA requests.

Refer to Attachment 1 for specific definitions of these modifiers and the procedure codes to which they apply.

### *Revenue codes are required*

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

### *Time units*

Providers will be required to bill all procedure codes in even hour or half-hour increments rounded to the nearest half hour. Refer to Attachment 3 for new rounding guidelines.

### *Type of service codes*

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

### *Place of service codes*

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes on PA requests.

All NIP providers will be required to use nationally recognized modifiers with procedure codes.

Allowable POS codes are as follows:

POS code	Description
03	School
12	Home
99	Other

*Note:* Place of service codes are not required on the UB-92 claim form.

#### *Coverage for private duty nursing and respiratory care services*

Medicaid coverage and documentation requirements for PDN and RCS remain unchanged. Refer to other Medicaid publications for complete Medicaid policies and procedures.

#### **Conversion from CMS 1500 paper claim to UB-92 paper claim**

With the implementation of HIPAA, Medicaid-certified NIP providers will be required to use the UB-92 paper claim form instead of the CMS 1500 paper claim form when submitting claims to Wisconsin Medicaid.

Any claims received on the CMS 1500 claim form after HIPAA implementation will be denied. Refer to Attachment 4 for instructions on completing the UB-92. Attachment 5 is a sample of a claim for PDN services that reflects the billing instructions for the UB-92;

Attachment 6 is a sample of a claim for RCS that reflects the billing instructions for the UB-92.

*Note:* Electronic claim formats will also change. Providers should contact their software vendor for electronic billing instructions.

#### *General changes to claim form instructions*

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

- Spenddown amount (value code "22") should not be entered in Form Locators 39-41 a-d. Wisconsin Medicaid will automatically reduce the provider's

reimbursement by the amount of the recipient's spenddown amount.

- Other insurance disclaimer codes revised (Form Locator 84 a-d).

#### *Obtaining and submitting UB-92 claim forms*

Wisconsin Medicaid does not supply the UB-92 claim form. Forms may be obtained from a number of commercial form suppliers. One such source is the Standard Register, which can be contacted at:

Standard Register  
PO Box 6248  
Madison WI 53716  
(608) 222-4131

Completed UB-92 claim forms should be mailed to:

Wisconsin Medicaid  
Claims and Adjustments  
6406 Bridge Rd  
Madison WI 53784-0002

#### **Revision of prior authorization forms and instructions**

With the implementation of HIPAA, NIP 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 7. A sample PA/RF for PDN services is in Attachment 8; a sample PA/RF for RCS is in Attachment 9. A sample PA/RF for RCS including a request for case coordination is in Attachment 10.

#### *Revisions made to the Prior Authorization Request Form*

The following revisions were made to the PA/RF:

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

With the implementation of HIPAA, Medicaid-certified NIP providers will be required to use the UB-92 paper claim form instead of the CMS 1500 paper claim form when submitting claims to Wisconsin Medicaid.

### *Prior authorization attachments*

Some of the PA attachments for PDN and RCS have also been revised. The basic information requested on the forms has not changed; only the format of the forms has changed.

Private duty nurses must submit the following attachments with the PA/RF:

- Plan of Care (CMS-485). This form has not been revised and a sample has not been included with this *Update*. Continue to use the current CMS-485 instructions and form.
- Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form, HCF 11041, dated 06/03. Attachment 11 is a copy of the Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form for providers to photocopy.

Respiratory care services providers must submit the following attachments with the PA/RF:

- Plan of Care (CMS-485). This form has not been revised and a sample has not been included with this *Update*. Continue to use the current CMS-485 instructions and form.
- Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form, HCF 11041, dated 06/03. Attachment 11 is a copy of the Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form for providers to photocopy.
- Respiratory Care Services Plan of Care (RCS/POC), HCF 11043, dated 06/03. Refer to Attachment 12 for a copy of the completion instructions for the RCS/POC. Attachment 13 is a copy of the RCS/POC for providers to photocopy.

### *Revisions made to the Prior*

#### *Authorization Amendment Request form*

The Prior Authorization Amendment Request form, HCF 11042, dated 06/03, has also been revised. All NIP providers will be required to use the revised form if changes must be made to the original PA/RF. Refer to Attachment 14 for a copy of the completion instructions for the Prior Authorization Amendment Request form. Attachment 15 is a copy of the Prior Authorization Amendment Request form for providers to photocopy.

#### *Obtaining prior authorization request forms*

The Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form, RCS/POC, and Prior Authorization Amendment Request form are 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 Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form, RCS/POC, Prior Authorization Amendment Request form, and other Medicaid forms, follow these instructions:

1. Go to [www.dhfs.state.wi.us/medicaid/](http://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 completed

\* 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/](http://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 Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form, RCS/POC, and Prior Authorization Amendment Request form are available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site.

electronically. 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 Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment form, RCS/POC, Prior Authorization Amendment Request form, or PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883.

Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

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

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

### General HIPAA information

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

- [www.cms.gov/hipaa/](http://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/](http://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/](http://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/](http://www.dhfs.state.wi.us/medicaid/).

## ATTACHMENT 1

## Procedure code conversion chart for private duty nursing and respiratory care services

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

The following table lists the nationally recognized procedure codes that nurses in independent practice will be required to use when submitting claims for private duty nursing and respiratory care services. A separate *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 services)	Modifier	Start-of-shift modifier
<b>W9041</b> Private duty LPN* — out-of-home/vent dependent	<b>99504</b> Home visit for mechanical ventilation care, per hour***	<b>TE</b> LPN	<b>UJ</b> — Night (12 a.m. to 5:59 a.m.)
<b>W9967</b> Respiratory Care — LPN			<b>UF</b> — Morning (6 a.m. to 11:59 a.m.)
<b>W9042</b> Private duty RN** — out-of-home/vent dependent		<b>TD</b> RN	<b>UG</b> — Afternoon (12 p.m. to 5:59 p.m.)
<b>W9968</b> Respiratory Care — RN			<b>UH</b> — Evening (6 p.m. to 11:59 p.m.)
<b>W9042</b> Private duty RN — out-of-home/vent dependent/ case coordination		<b>U1</b> RN Case Coordinator	<b>UJ</b> — Night (12 a.m. to 5:59 a.m.)
			<b>UF</b> — Morning (6 a.m. to 11:59 a.m.)
			<b>UG</b> — Afternoon (12 p.m. to 5:59 p.m.)
			<b>UH</b> — Evening (6 p.m. to 11:59 p.m.)
<b>W9045</b> Private duty LPN	<b>S9124</b> Nursing care, in the home; by licensed practical nurse, per hour***	None	<b>UJ</b> — Night (12 a.m. to 5:59 a.m.)
			<b>UF</b> — Morning (6 a.m. to 11:59 a.m.)
			<b>UG</b> — Afternoon (12 p.m. to 5:59 p.m.)
			<b>UH</b> — Evening (6 p.m. to 11:59 p.m.)
<b>W9046</b> Private duty RN	<b>S9123</b> Nursing care, in the home; by registered nurse, per hour***	None	<b>UJ</b> — Night (12 a.m. to 5:59 a.m.)
			<b>UF</b> — Morning (6 a.m. to 11:59 a.m.)
			<b>UG</b> — Afternoon (12 p.m. to 5:59 p.m.)
			<b>UH</b> — Evening (6 p.m. to 11:59 p.m.)

\* RN = Registered nurse.

\*\* LPN = Licensed practical nurse.

\*\*\* Refer to Attachment 3 of this *Update* for information about rounding guidelines.

# ATTACHMENT 2

## National Uniform Billing Code revenue codes for private duty nursing and respiratory care services

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

Code	Service description
0550	Skilled Nursing
0969	Other Professional Fees

For the most current and complete list of revenue codes, contact the American Hospital Association National Uniform Billing Committee (NUBC) 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/](http://www.nubc.org/).

# ATTACHMENT 3

## Rounding guidelines for private duty nursing and respiratory care services

Providers will be required to use the following guidelines to bill even hours or half-hour increments rounded to the nearest half hour in Form Locator 46 of the UB-92 (CMS 1450) claim form.

Time (in minutes)	Unit(s) billed
1-30	0.5
31-44	0.5
45-60	1.0
61-74	1.0
75-90	1.5
91-104	1.5
105-120	2.0
121-134	2.0
Etc.	

# ATTACHMENT 4

## UB-92 (CMS 1450) claim form instructions for private duty nursing and respiratory care services of nurses in independent practice

(For claims submitted after HIPAA implementation)

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

These instructions are for the completion of the UB-92 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Uniform 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/](http://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 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/](http://www.dhfs.state.wi.us/medicaid/) for more information about the EVS.

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

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

### **Form Locator 2 — Unlabeled Field (not required)**

### **Form Locator 3 — Patient Control No. (optional)**

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. Providers of private duty nursing (PDN) and respiratory care services (RCS) are required to bill

type “33X”. The third digit (“X”) indicates the billing frequency and should be assigned as follows:

- 1 = Inpatient admit through discharge claim
- 2 = Interim bill — first claim
- 3 = Interim bill — continuing claim
- 4 = Interim bill — 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**

Enter the complete address of the recipient’s place of residence.

**Form Locator 14 — Birthdate**

Enter the recipient’s birth date in MM/DD/YY format (e.g., September 25, 1975, would be 092575) or in MM/DD/YYYY format (e.g., September 25, 1975, would be 09251975).

**Form Locator 15 — Sex**

Specify if the recipient is male with an “M” or female with an “F.” If the recipient’s sex is unknown, enter “U.”

**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 Wisconsin Medicaid R/S Report 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 must 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 (required, if applicable)**

Enter the appropriate five-digit procedure code, followed by as many as four modifiers.

**Form Locator 45 — Serv. Date**

Enter the DOS in the MMDDYY format either in this form locator 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 time units. For each DOS, indicate even hours or half-hour increments rounded to the nearest half hour (one hour = one unit). If billing multiple DOS on a single line, the time units indicated must be evenly divisible by the number of days indicated on the line.

**Form Locator 47 — Total Charges**

Enter the usual and customary charges for each line. Enter revenue code “0001” to report the sum of all charges in Form Locator 47.

**Form Locator 48 — Non-covered Charges (not required)****Form Locator 49 — Unlabeled Field (not required)****Form Locator 50 A-C — Payer**

Enter all health insurance payers here. For example, enter “T19” for Wisconsin Medicaid and/or the name of commercial health insurance.

**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 with the name in Form Locator 1.

**Form Locator 52 A-C — Rel Info (not required)****Form Locator 53 A-C — Asg Ben (not required)****Form Locator 54 A-C & P — Prior Payments (required, if applicable)**

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter “000.”

**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 PA requests 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) (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). 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. Diagnosis description is not required. Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code.

**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**

Enter the name and the Unique Physician Identification Number, eight-digit Wisconsin Medicaid provider number, or license number for both PDN and RCS claims.

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

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

### *Commercial health insurance billing information*

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

If the EVS indicates that the recipient has dental (“DEN”) or has no commercial health insurance, leave Form Locator 84 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** line of Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"><li>✓ The recipient denied coverage or will not cooperate.</li><li>✓ The provider knows the service in question is not covered by the carrier.</li><li>✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims.</li><li>✓ Benefits are not assignable or cannot get assignment.</li><li>✓ Benefits are exhausted.</li></ul>

*Note:* The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

## 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 private duty nursing services

APPROVED OMB NO. 0938-0279

IM PROVIDER 987 N ELM ST ANYTOWN, WI 55555 (555) 321-1234		2		3 PATIENT CONTROL NO.		4 TYPE OF BILL 333	
		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 RECIPIENT, IMA H.				13 PATIENT ADDRESS 1234 OAK ST ANYTOWN, WI 55555			
14 BIRTHDATE 092775		15 SEX F		16 MS		17 DATE	
18 HR		19 TYPE		20 SRC		21 D HR	
22 STAT		23 MEDICAL RECORD NO. 03 7654321		24		25	
32 OCCURRENCE DATE		34 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37	
38		39 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATES		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0550	120103	S9123 UH		4.0	XXX	XX
2	0550	120203	S9123 UJ UH		8.0	XXX	XX
3	0550	120303	S9123 UJ		4.0	XXX	XX
4							
5	0001	TOTAL CHARGES				XXXX	XX
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
50 PAYER XYZ INSURANCE T19 MEDICAID		51 PROVIDER NO. 87654321		52 REL INFO 53 ASG BEN		54 PRIOR PAYMENTS XXX XX	
55 EST AMOUNT DUE		56		57 <b>DUE FROM PATIENT</b>		58	
58 INSURED'S NAME		59 P.REL.		60 CERT. - SSN - HIC - ID NO. 1234567890		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES 1234567		64 ESC		65 EMPLOYER NAME	
66 EMPLOYER LOCATION		67 PRIN. DIAG. CD 344.00		68 CODE		69 CODE	
70 CODE		71 CODE		72 CODE		73 CODE	
74 CODE		75 ADM. DIAG. CD		76 E-CODE		78	
79 P.C.		80 PRINCIPAL PROCEDURE DATE		81 OTHER PROCEDURE DATE		82 ATTENDING PHYS. ID IM PRESCRIBING X12345	
83 OTHER PHYS. ID		84 REMARKS OI-P		85 PROVIDER REPRESENTATIVE X I.M. Provider		86 DATE 120103	

UB-92 HCFA-1450

OCR/Original

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



# ATTACHMENT 7

## Prior Authorization Request Form (PA/RF)

### Completion Instructions for private duty nursing and respiratory care services of nurses in independent practice

(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 CMS-485, the Respiratory Care Services/Plan of Care (RCS/POC), and/or the Prior Authorization Amendment Form, 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 Element 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 place of business of the billing provider.

### **Element 3 — Processing Type**

Enter three-digit processing type “120” — Home Health/Nurses in Independent Practice/Respiratory Care Services. The processing type is 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 *Current Procedural Terminology* (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code.

**Element 17 — Modifiers**

For respiratory care services (RCS), providers must enter either modifier “TE” (licensed practical nurse [LPN]) or “TD” (registered nurse [RN]) corresponding to the procedure code listed in Attachment 1. If RCS case coordination services will be provided, modifier “U1” must also be indicated. For private duty nursing (PDN), providers do not enter a modifier.

**Element 18 — POS**

Enter the appropriate place of service (POS) code(s) designating where the requested service would be provided.

POS	Description
03	School
12	Home
99	Other Place of Service

**Element 19 — Description of Service**

Enter a written description corresponding to the appropriate CPT code or HCPCS code listed. Indicate in the description the credentials of the individual who provided the service (e.g., LPN, RN). When requesting PDN or RCS, indicate the number of hours per day, number of days per week, multiplied by the total number of weeks being requested.

The name and license number of the RN coordinator of services must be indicated in this element. Also, the LPN must indicate the name and license number of the supervising RN.

If sharing a case with another provider, enter “shared case” and include a statement that the total number of hours of all providers will not exceed the combined total number of hours ordered on the physician’s plan of care.

**Element 20 — QR**

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

**Element 21 — Charge**

Enter the usual and customary charge for each service requested.

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

**Element 22 — Total Charges**

Enter the anticipated total charge for this request. If 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 performing 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 8

## Sample Prior Authorization Request Form (PA/RF) for private duty nursing 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.

<b>FOR MEDICAID USE — ICN</b>	AT	Prior Authorization Number
-------------------------------	----	----------------------------

<b>SECTION I — PROVIDER INFORMATION</b>		
<b>1. Name and Address — Billing Provider (Street, City, State, Zip Code)</b>  <b>I.M. Provider</b> <b>987 N Elm St</b> <b>Anytown WI 55555</b>	<b>2. Telephone Number — Billing Provider</b> <b>(555) 123-4567</b>	<b>3. Processing Type</b>  <b>120</b>
<b>4. Billing Provider's Medicaid Provider Number</b> <b>87654321</b>		

<b>SECTION II — RECIPIENT INFORMATION</b>		
<b>5. Recipient Medicaid ID Number</b> <b>1234567890</b>	<b>6. Date of Birth — Recipient (MM/DD/YY)</b> <b>01/14/02</b>	<b>7. Address — Recipient (Street, City, State, Zip Code)</b> <b>1234 Oak St</b> <b>Anytown WI 55555</b>
<b>8. Name — Recipient (Last, First, Middle Initial)</b> <b>Recipient, Ima A.</b>	<b>9. Sex — Recipient</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F	

<b>SECTION III — DIAGNOSIS / TREATMENT INFORMATION</b>										
<b>10. Diagnosis — Primary Code and Description</b> <b>770.7 — Bronchopulmonary dysplasia</b>					<b>11. Start Date — SOI</b>		<b>12. First Date of Treatment — SOI</b>			
<b>13. Diagnosis — Secondary Code and Description</b> <b>343.9 — Infantile cerebral palsy</b>					<b>14. Requested Start Date</b> <b>11/01/03</b>					
<b>15. Performing Provider Number</b>	<b>16. Procedure Code</b> <b>S9124</b>	<b>17. Modifiers</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black;">1</td> <td style="width: 25%; border: 1px solid black;">2</td> <td style="width: 25%; border: 1px solid black;">3</td> <td style="width: 25%; border: 1px solid black;">4</td> </tr> </table>	1	2	3	4	<b>18. POS</b> <b>12, 99</b>	<b>19. Description of Service</b> <b>LPN/PDN not to exceed 12 hours per 24-hour period and 60 hours per calendar week, all Medicaid recipients combined</b>  <b>Coordinator: name, license number</b>	<b>20. QR</b> <b>3,120 hrs</b>	<b>21. Charge</b> <b>XX.XX</b>
1	2	3	4							

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.

<b>23. SIGNATURE — Requesting Provider</b> <div style="text-align: center; font-size: 1.2em; font-weight: bold; margin-top: 10px;">I. M. Requesting</div>	<b>24. Date Signed</b> <b>10/07/03</b>
--	---

<b>FOR MEDICAID USE</b>	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved		
<div style="display: flex; justify-content: space-around; width: 100%;"> <span>Grant Date</span> <span>Expiration Date</span> </div>		
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		
_____ <b>SIGNATURE — Consultant / Analyst</b>		_____ Date Signed

# ATTACHMENT 9

## Sample Prior Authorization Request Form (PA/RF) for respiratory 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.

<b>FOR MEDICAID USE — ICN</b>	AT	Prior Authorization Number
-------------------------------	----	----------------------------

**SECTION I — PROVIDER INFORMATION**

1. Name and Address — Billing Provider (Street, City, State, Zip Code)  <b>I.M. Provider 987 N Elm St Anytown WI 55555</b>	2. Telephone Number — Billing Provider <b>(555) 123-4567</b>	3. Processing Type  <b>120</b>
4. Billing Provider's Medicaid Provider Number <b>87654321</b>		

**SECTION II — RECIPIENT INFORMATION**

5. Recipient Medicaid ID Number <b>1234567890</b>	6. Date of Birth — Recipient (MM/DD/YY) <b>06/25/68</b>	7. Address — Recipient (Street, City, State, Zip Code) <b>1234 Oak St Anytown WI 55555</b>
8. Name — Recipient (Last, First, Middle Initial) <b>Recipient, Ima A.</b>		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

**SECTION III — DIAGNOSIS / TREATMENT INFORMATION**

10. Diagnosis — Primary Code and Description <b>V46.1 — Respirator</b>				11. Start Date — SOI		12. First Date of Treatment — SOI	
13. Diagnosis — Secondary Code and Description <b>335.20 — ALS</b>				14. Requested Start Date <b>12/01/03</b>			
15. Performing Provider Number	16. Procedure Code	17. Modifiers	18. POS	19. Description of Service	20. QR	21. Charge	
	<b>99504</b>	<b>TE</b>	<b>12, 99</b>	<b>LPN/RCS not to exceed 12 hours per 24-hour period and 60 hours per calendar week, all Medicaid recipients combined</b>	<b>3,120 hrs</b>	<b>XX.XX</b>	
				<b>Coordinator: name, license number</b>			
				<b>Supervising RN: name, license number</b>			

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  <div style="text-align: center; font-size: 1.2em;"><b><i>I. M. Requesting</i></b></div>	24. Date Signed <b>11/09/03</b>
--	------------------------------------

<b>FOR MEDICAID USE</b>	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved <div style="text-align: center; margin-left: 100px;">             _____ Grant Date      _____ Expiration Date           </div>		
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		
_____ <b>SIGNATURE</b> — Consultant / Analyst		_____ Date Signed

# ATTACHMENT 10

## Sample Prior Authorization Request Form (PA/RF) for respiratory care services with a request for case coordination

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.

<b>FOR MEDICAID USE — ICN</b>	AT	Prior Authorization Number
-------------------------------	----	----------------------------

<b>SECTION I — PROVIDER INFORMATION</b>		
1. Name and Address — Billing Provider (Street, City, State, Zip Code)  <b>I.M. Provider 987 N Elm St Anytown WI 55555</b>	2. Telephone Number — Billing Provider <b>(555) 123-4567</b>	3. Processing Type  <b>120</b>
4. Billing Provider's Medicaid Provider Number <b>87654321</b>		

<b>SECTION II — RECIPIENT INFORMATION</b>		
5. Recipient Medicaid ID Number <b>1234567890</b>	6. Date of Birth — Recipient (MM/DD/YY) <b>06/25/68</b>	7. Address — Recipient (Street, City, State, Zip Code) <b>1234 Oak St Anytown WI 55555</b>
8. Name — Recipient (Last, First, Middle Initial) <b>Recipient, Ima A.</b>		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

<b>SECTION III — DIAGNOSIS / TREATMENT INFORMATION</b>						
10. Diagnosis — Primary Code and Description <b>V46.1 — Respirator</b>				11. Start Date — SOI		12. First Date of Treatment — SOI
13. Diagnosis — Secondary Code and Description <b>335.20 — ALS</b>				14. Requested Start Date <b>12/01/03</b>		
15. Performing Provider Number	16. Procedure Code <b>99504</b>	17. Modifiers 1   2   3   4 <b>TD</b>	18. POS <b>12, 99</b>	19. Description of Service <b>RN/RCS not to exceed 12 hours per 24-hour period and 60 hours per calendar week, all Medicaid recipients combined</b>	20. QR <b>3,060 hrs</b>	21. Charge <b>XX.XX</b>
	<b>99504</b>	<b>U1</b>		<b>Case coordination 5 hrs/month x 12 months</b>	<b>60 hrs</b>	<b>XX.XX</b>
				<b>Coordinator: name, license number</b>		

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.

23. SIGNATURE — Requesting Provider  <div style="text-align: center; font-size: 1.2em; font-weight: bold;">I. M. Requesting</div>	24. Date Signed <b>11/09/03</b>
---	------------------------------------

<b>FOR MEDICAID USE</b>	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved <div style="text-align: center; margin-top: 10px;">             _____ Grant Date                      Expiration Date           </div> <input type="checkbox"/> Modified — Reason:  <input type="checkbox"/> Denied — Reason:  <input type="checkbox"/> Returned — Reason:		
_____ SIGNATURE — Consultant / Analyst		_____ Date Signed

ATTACHMENT 11  
Private Duty Nursing / Respiratory Care Services  
Prior Authorization Acknowledgment  
(for photocopying)

(A copy of the "Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment" [for photocopying] is located on the following page.)

**WISCONSIN MEDICAID  
PRIVATE DUTY NURSING / RESPIRATORY CARE SERVICES PRIOR AUTHORIZATION  
ACKNOWLEDGMENT**

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. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

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

**INSTRUCTIONS**

1. Allow the recipient, or recipient's parent, guardian, or legal representative, to read the plan of care and prior authorization (PA) request. Answer any questions the recipient may have.
2. Have the recipient or the recipient's legal health care designee sign and date this form.
3. Attach this completed form to the Prior Authorization Request Form (PA/RF) and/or Prior Authorization Amendment Request for private duty nursing (PDN) and/or respiratory care services (RCS).
4. For more information on PDN and RCS documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Name — Recipient	Wisconsin Medicaid Identification Number
------------------	--

Prior Authorization Number
----------------------------

**I have read the attached Plan of Care and the PA request.**

Name — Person Signing Form (print)	Relationship to Recipient (if person signing form is not recipient)
------------------------------------	--

<b>SIGNATURE</b>  Check one: <input type="checkbox"/> Recipient <input type="checkbox"/> Recipient's Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Representative	Date Signed
---	-------------

ATTACHMENT 12  
Respiratory Care Services / Plan of Care (RCS/POC)  
Completion Instructions (for photocopying)

(A copy of the “Respiratory Care Services/Plan of Care [RCS/POC] Completion Instructions” [for photocopying] is located on the following pages.)

(This page intentionally left blank.)

## WISCONSIN MEDICAID RESPIRATORY CARE SERVICES / PLAN OF CARE (RCS/POC) 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 on this form 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 judgment about the case.

### Submitting Prior Authorization Requests

These instructions are for the plan of care that providers are to attach to PA requests for respiratory care services (RCS). Attach the completed Respiratory Care Services/Plan of Care (RCS/POC) to the Prior Authorization Request Form (PA/RF) when submitting a PA request for RCS.

Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to continue submitting 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

### Comments Sections on RCS / POC

The comments sections throughout this document should be used to provide additional information if necessary.

## SECTION I ? RECIPIENT / PROVIDER INFORMATION

Include all of the following information on the areas marked on the top of each page of the RCS/POC.

### Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial.

### Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System to obtain the correct identification number.

### Name — Provider

Enter the provider's name.

### Wisconsin Medicaid Provider Number

Enter the provider's Medicaid number. Use the billing number the provider will use on Medicaid claims.

## SECTION II ? RESPIRATORY CARE SERVICES REQUESTED

### Service (Airway Management)

Answer all questions in this subsection. Where requested, indicate the frequency of the care in the units indicated. If airway humidification is required, indicate at least one type of humidification used.

**List Scope of at Least Three Parameters**

Indicate at least three parameters to be monitored (e.g., vital signs, breath sounds, and secretions). For each parameter, indicate the number of times that parameter is monitored in a 24-hour period.

**Service (Ventilatory Support)**

Answer all questions in this subsection. Where requested, indicate the number of hours that mode of ventilation is used in a 24-hour period. In addition, if the mode of ventilation is "Other," specify the type of ventilation used and frequency.

List at least two parameters used for monitoring the ventilator (e.g., ventilator and alarm settings), and indicate the frequency for each parameter (the number of hours in a 24-hour period).

Identify at least one step in the provider's plan for ventilator maintenance, and indicate the number of times per week that step is performed.

**SECTION III ? EMERGENCY PLAN**

Answer all questions in this section. If there are no events to which this recipient is susceptible, record "NONE."

List at least two resources (e.g., emergency equipment, an emergency power source) used for back-up equipment.

Identify at least one monitoring device or adjunctive technique used by the recipient, and indicate the frequency for each (the number of times in a 24-hour period).

**SECTION IV ? FUTURE AND OTHER CARES**

If recipient is to be weaned from the ventilator, complete the appropriate questions.

Indicate whether the recipient is receiving other services by checking the appropriate box(es).

**SECTION V ? CASE COORDINATION**

Complete all applicable information about case coordination and the case coordinator for this recipient.

**SIGNATURE**

Sign and date the RCS/POC. If the form is not signed by the applicable individuals, the entire PA request will be returned to the provider.

ATTACHMENT 13  
Respiratory Care Services / Plan of Care (RCS/POC)  
(for photocopying)

(A copy of the "Respiratory Care Services/Plan of Care [RCS/POC]"  
[for photocopying] is located on the following pages.)

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**WISCONSIN MEDICAID  
 RESPIRATORY CARE SERVICES / PLAN OF CARE (RCS/POC)**

**Instructions:** Type or print clearly. Before completing this form, read the Respiratory Care Services/Plan of Care (RCS/POC) Completion Instructions (HCF 11043A).

<b>SECTION I — RECIPIENT / PROVIDER INFORMATION</b>	
Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Provider	Wisconsin Medicaid Provider Number

<b>SECTION II — RESPIRATORY CARE SERVICES REQUIRED</b>		
Service (Airway Management) (check if applicable)	Frequency	Comments
<input type="checkbox"/> Stoma	Times per 24-hour period	
<input type="checkbox"/> Tube change	Times per month	
<input type="checkbox"/> Suctioning — Nasal	Times per 24-hour period	
<input type="checkbox"/> Suctioning — Tracheal	Times per 24-hour period	
<input type="checkbox"/> Suctioning — Oral / Pharyngeal	Times per 24-hour period	
<input type="checkbox"/> Airway humidification used with ventilator 1.	Hours per 24-hour period	
2.		
<input type="checkbox"/> Airway humidification used if off ventilator 1.	Hours per 24-hour period	
2.		
<input type="checkbox"/> Supplemental oxygen		
<b>List scope of at least three parameters to be monitored for recipient (e.g., vital signs, breath sounds, secretions)</b>	<b>Times per 24-hour period parameter assessment completed</b>	<b>Comments</b>
1.		
2.		
3.		
4.		
5.		
6.		

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Provider	Wisconsin Medicaid Provider Number

**SECTION II — RESPIRATORY CARE SERVICES REQUIRED (Continued)**

Service (Ventilatory Support) (check if applicable)	Frequency	Comments
<input type="checkbox"/> Ventilatory support — Positive pressure	Hours per 24-hour period	
<input type="checkbox"/> Ventilatory support — Negative pressure (e.g., poncho)	Hours per 24-hour period	
<input type="checkbox"/> Other (list type)	List frequency	
<input type="checkbox"/> Monitoring ventilator (list at least two parameters below)	Hours per 24-hour period	
1.		
2.		
3.		
4.		
<input type="checkbox"/> Ventilator maintenance (list at least one parameter below)	Times per week	
1.		
2.		
3.		
4.		

**SECTION III — EMERGENCY PLAN**

Is an emergency plan written and available?     Yes     No

Is airway management disruption (e.g., decannulation) life threatening for recipient?     Yes     No

List specific events (if any) to which this recipient is susceptible (e.g., severe bronchospasm).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Emergency plan available for following areas?	Yes	No	Comments
Airway management			
Disaster plan (e.g., for tornado or fire)			
Hospitalization			
Hypoxic events			
Oxygen supply depletion			
Resuscitation			
Respiratory compromise			
Ventilatory equipment failure			
Transportation			
Other (list below)			

*Continued*

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Provider	Wisconsin Medicaid Provider Number

**SECTION III — EMERGENCY PLAN (Continued)**

List back-up equipment available (list at least two resources [e.g., emergency equipment or power sources] below).

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Arrangement for emergency / acute care?  Yes  No  
 Comments \_\_\_\_\_

Recipient requires monitoring devices?  Yes (list below)  No

Device	Frequency	Comments
1.		
2.		
3.		
4.		

Recipient requires adjunctive techniques (e.g., chest physiotherapy, aerosolized meds)?  Yes (list below)  No

Type	Frequency	Comments
1.		
2.		
3.		
4.		

**SECTION IV — FUTURE AND OTHER CARES**

Recipient is expected to be weaned from ventilator?  Yes  No

Identify time period from today's date when weaning program would begin. \_\_\_\_\_ Weeks \_\_\_\_\_ Months

Is there a written plan for weaning program available?  Yes  No

Recipient is receiving other services?  Yes (check applicable services below)  No

<input type="checkbox"/> Dental	<input type="checkbox"/> Physician (specialty) _____
<input type="checkbox"/> Disposable Medical Supplies	<input type="checkbox"/> Psychotherapy
<input type="checkbox"/> Drugs	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Social
<input type="checkbox"/> Educational	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Nutritional	<input type="checkbox"/> Vocational
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other (list): _____
<input type="checkbox"/> Physical Therapy	_____

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Provider	Wisconsin Medicaid Provider Number

**SECTION V — CASE COORDINATION**

Plan is in place for coordination of services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Case coordinator has been designated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am the case coordinator.	<input type="checkbox"/> Yes	<input type="checkbox"/> No (name of case coordinator) _____

Describe other pertinent respiratory care needs below.

List any other comments below.

<b>SIGNATURE</b> — Nurse	Position Title	Date Signed
<b>SIGNATURE</b> — Physician	Position Title	Date Signed

ATTACHMENT 14  
Prior Authorization Amendment Request Completion  
Instructions (for photocopying)

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

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## 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 PA 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 on 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 on 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 on 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, 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 15  
Prior Authorization Amendment Request  
(for photocopying)

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

**WISCONSIN MEDICAID  
PRIOR AUTHORIZATION AMENDMENT REQUEST**

Providers may submit prior authorization (PA) amendment 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 PA 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, 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. <b>SIGNATURE</b> — Requesting Provider	12. Date Signed
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