

To:
Home Health
Agencies
HMOs and Other
Managed Care
Programs

Changes to local codes, paper claims, and prior authorization for home health services, including private duty nursing and respiratory 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 home health services, including 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.
- Revising UB-92 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 home health services, including 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), but 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 and returned PA requests. Specific implementation dates will be published in a separate *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for home health 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 local procedure codes (W9030-W9969) for home health services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers must use the appropriate HCPCS or CPT procedure code that describes the service performed.

Providers should continue to refer to their service-specific *Updates* and handbooks (e.g., durable medical equipment, disposable medical supplies) for other nationally recognized procedure codes that Wisconsin Medicaid covers.

Revenue codes are required

Wisconsin Medicaid will adopt nationally recognized four-digit revenue codes for home health services. Providers will be required to use a revenue code with a preceding “0” before a three-digit revenue code when submitting claims for home health 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 Committee. Providers should use the appropriate revenue code that best describes the service performed.

Modifiers

Providers will be required to use nationally recognized modifiers for claims and PA requests.

Providers are required to use nationally recognized modifiers, including state-defined start-of-shift modifiers on claims using the following guidelines:

- Choose the start-of-shift modifier that most closely represents the time each shift began. For each day, enter the start-of-shift 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 9 for an example of a claim for a shift whose hours cross midnight.

- A provider will not be able to enter more than four modifiers for each date of service.

Refer to Attachment 1 for the new modifiers and the procedure codes to which they apply.

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 4 for new rounding guidelines.

Coverage for home health services

Medicaid coverage and documentation requirements for home health services remain unchanged. Refer to the Home Health Handbook, the Respiratory Care Services Handbook, and *Updates* for complete Medicaid policies and procedures.

Revision of UB-92 paper claim instructions

With the implementation of HIPAA, Medicaid-certified home health services providers are 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 5 for the revised instructions. Refer to the following attachments for samples of claims that reflect the changes to the billing instructions:

- Attachment 6 is a sample of a claim for skilled nursing and aide services.
- Attachment 7 is a sample of a claim for home health therapy services.
- Attachment 8 is a sample of a claim for RCS showing use of billing for individual dates of service and series billing.
- Attachment 9 is a sample of a claim for PDN services showing billing for a shift with hours that cross midnight.

Providers will be required to use nationally recognized modifiers for claims and PA requests.

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).
- Medicare and other insurance disclaimer codes revised (Form Locator 84 a-d).

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, home health services 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 10. Refer to the following attachments for samples of PA/RFs:

- Attachment 11 is a sample PA/RF for skilled nursing and aide services.
- Attachment 12 is a sample PA/RF for home health therapy services.
- Attachment 13 is a sample PA/RF for RCS.
- Attachment 14 is a sample PA/RF for PDN services.

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 replace the one-digit POS codes used currently by Wisconsin Medicaid (Element 18). Refer to Attachment 3 for a list of allowable POS codes for home health services.
- Type of service codes no longer required on PA requests.

Prior authorization attachments

The prior authorization attachments used by home health agencies have also been revised. The basic information requested on the forms has not changed; only the format of the forms has changed. The following attachments have been revised:

- The Prior Authorization/Home Health Therapy Attachment (PA/HHTA), HCF 11044, dated 06/03. Refer to Attachment 15 for a copy of the completion instructions for the PA/HHTA. Attachment 16 is a copy of the PA/HHTA for providers to photocopy.
- The Respiratory Care Services/Plan of Care (RCS/POC), HCF 11043, dated 06/03. Refer to Attachment 17 for a copy of the completion instructions for the RCS/POC. Attachment 18 is a copy of the RCS/POC for providers to photocopy.
- The Prior Authorization Amendment Request, HCF 11042, dated 06/03. Refer to Attachment 19 for a copy of the completion instructions for the amendment request form. Attachment 20 is a copy of the form for providers to photocopy.
- The Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment, HCF 11041, dated 06/03. Attachment 21 is a copy of the form, including completion instructions, for providers to photocopy.

Providers must continue to send applicable attachments with all PA requests (such as the

The prior authorization attachments used by home health agencies have also been revised. The basic information requested on the forms has not changed; only the format of the forms has changed.

CMS 485, formerly known as the HCFA 485) as indicated in their service-specific handbooks and *Updates*.

Obtaining prior authorization request forms

The prior authorization attachments 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 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/HHTA, RCS/POC, Prior Authorization Amendment Request, 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.

* 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.

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

Information regarding Medicaid HMOs

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

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

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

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

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

ATTACHMENT 1

Procedure code conversion chart for home health services

The following table lists the Healthcare Common Procedure Coding System (HCPCS) procedure code or *Current Procedural Terminology* (CPT) code that providers will be required to use when submitting claims for home health services, including 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 service)	National modifier	State-defined start-of-shift modifier	Place of service (POS) code*
W9030 Private duty nurse — licensed practical nurse	Discontinued August 1, 2003			
W9031 Private duty nursing — registered nurse	Discontinued August 1, 2003			
W9041 Private duty licensed practical nurse — out-of-home/vent dependent	99504 Home visit for mechanical ventilation care [per hour]**	TE Licensed practical nurse	UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)	03, 12, 99
W9042 Private duty registered nurse — out-of-home/vent dependent	99504 Home visit for mechanical ventilation care [per hour]**	TD Registered nurse	UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)	03, 12, 99

*Refer to Attachment 3 of this *Update* for POS code descriptions.

**Refer to Attachment 4 for information about rounding guidelines.

Before HIPAA implementation	After HIPAA implementation			
Local procedure code and description	National procedure code and description (Limited to current Wisconsin Medicaid covered service)	National modifier	State-defined start-of-shift modifier	POS codes*
<p>W9045 Private duty licensed practical nurse</p>	<p>S9124 Nursing care, in the home; by licensed practical nurse, per hour**</p>	None	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	03, 12, 99
<p>W9046 Private duty registered nurse</p>	<p>S9123 Nursing care, in the home; by registered nurse, per hour**</p>	None	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	03, 12, 99
<p>W9919 Home health physical therapy</p>	<p>97799 Unlisted physical medicine/rehabilitation service or procedure [per visit]</p>	None	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	12
<p>W9920 Home health occupational therapy</p>	<p>97139 Unlisted therapeutic procedure (specify) [per visit]</p>	None	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	12

*Refer to Attachment 3 for POS code descriptions.

**Refer to Attachment 4 for information about rounding guidelines.

Before HIPAA implementation	After HIPAA implementation			
Local procedure code and description	National procedure code and description (Limited to current Wisconsin Medicaid covered service)	National modifier	State-defined start-of-shift modifier	POS code*
<p align="center">W9921 Home health speech therapy</p>	<p align="center">92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual [per visit]</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p align="center">12</p>
<p align="center">W9925 Ongoing assessment</p>	<p align="center">T1001 Nursing assessment/evaluation [per visit]</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p align="center">12</p>
<p align="center">W9930 Home health nursing <i>initial</i> visit</p>	<p align="center">99600 Unlisted home visit service or procedure [per visit]</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p align="center">12</p>
<p align="center">W9931 Home health aide <i>initial</i> visit</p>	<p align="center">T1021 Home health aide or certified nurse assistant, per visit</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p align="center">12</p>

*Refer to Attachment 3 for POS code descriptions.

Before HIPAA implementation	After HIPAA implementation			
Local procedure code and description	National procedure code and description (Limited to current Wisconsin Medicaid covered service)	National modifier	State-defined start-of-shift modifier	POS code*
<p>W9932 Home health medication management visit</p>	<p>T1502 Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit</p>	<p>None</p>	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p>12</p>
<p>W9940 Home health nursing <i>subsequent</i> visit</p>	<p>99600 Unlisted home visit service or procedure [per visit]</p>	<p>TS Follow-up service</p>	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p>12</p>
<p>W9941 Home health aid <i>subsequent</i> visit</p>	<p>T1021 Home health aide or certified nurse assistant, per visit</p>	<p>TS Follow-up service</p>	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p>12</p>
<p>W9964 Respiratory Care — HH/RN</p>	<p>99504 Home visit for mechanical ventilation care [per hour]**</p>	<p>TD Registered nurse</p>	<p>UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>	<p>03, 12, 99</p>

*Refer to Attachment 3 for POS code descriptions.

** Refer to Attachment 4 for information about rounding guidelines.

Before HIPAA implementation	After HIPAA implementation			
Local procedure code and description	National procedure code and description (Limited to current Wisconsin Medicaid covered service)	National modifier	State-defined start-of-shift modifier	POS code*
W9965 Respiratory Care — HH/LPN	99504 Home visit for mechanical ventilation care [per hour]**	TE Licensed practical nurse	UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)	03, 12, 99

*Refer to Attachment 3 for POS code descriptions.

** Refer to Attachment 4 for information about rounding guidelines.

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 home 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
0580	Other Home Health Services, Except Therapies
0420	Physical Therapy
0430	Occupational Therapy
0440	Speech and Language Pathology

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/.

ATTACHMENT 3

Allowable place of service codes for home care services

The following table lists the nationally recognized two-digit place of service (POS) codes that providers will be required to use when submitting prior authorization requests for home health services, including 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).

POS code	Description
03	School
12	Home
99	Other Place of Service

ATTACHMENT 4

Rounding guidelines for home care services

Providers are 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.

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

ATTACHMENT 5

UB-92 (CMS 1450) claim form instructions for home care services

(For claims submitted after HIPAA implementation)

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

These instructions are for the completion of the UB-92 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National 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/.

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

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 match 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 home care services 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 (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 Wisconsin Medicaid 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 a list of condition 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 a list of occurrence 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.

If billing a range of dates for the rental of durable medical equipment, the range of dates must be within a single calendar month and indicated in the following manner: MMDDYY–MMDDYY. 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, followed by as many as four modifiers. Separate the procedure code and the modifier(s) with commas.

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, ancillary units of service, or visits, where appropriate. Bill even hours or half-hour increments rounded to the nearest half hour. Refer to Attachment 4 of this *Wisconsin Medicaid and BadgerCare Update* for rounding guidelines for procedure codes in which one unit equals one hour.

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, or Form Locator 45. 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.” 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 the 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) (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.

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.

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”) 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 health 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 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">✓ 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.

Medicare information

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

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost (“MCC”) or Medicare + Choice (“MPC”), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

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

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none">✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.✓ The recipient is eligible for Medicare Part A.✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none">✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.✓ The recipient is eligible for Medicare Part B.✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none">✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.✓ The recipient is eligible for Medicare Part A.✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none">✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.✓ The recipient is eligible for Medicare Part B.✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Form Locator 85 — Provider Representative

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

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 7

Sample UB-92 claim form for home health therapy 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 332	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV D.	
8 N-C-D.		9 C-I-D.		10 L-R-D.	
11		12 PATIENT NAME RECIPIENT, I.M.A.			
13 PATIENT ADDRESS				14 BIRTHDATE	
15 SEX		16 MS		17 DATE	
18 HR		19 TYPE		20 SRC	
21 D HR		22 STAT		23 MEDICAL RECORD NO.	
24		25		26	
27		28		29	
30		31		32	
33		34		35	
36		37		38	
39		40		41	
42		43		44	
45		46		47	
48		49		50	
51		52		53	
54		55		56	
57		58		59	
60		61		62	
63		64		65	
66		67		68	
69		70		71	
72		73		74	
75		76		77	
78		79		80	
81		82		83	
84		85		86	
87		88		89	
90		91		92	

UB-92 HCFA-1450

OCR/Original

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

ATTACHMENT 8

Sample UB-92 claim form for respiratory care services

APPROVED OMB NO. 0938-0279

IM BILLING PROVIDER 1 W. WILLIAMS ANYTOWN, WI 55555 (555) 321-1234				2				3 PATIENT CONTROL NO. 12345ABCD				4 TYPE OF BILL 333												
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV D.		8 N-C.D.	9 C-I.D.	10 L-R.D.		11										
12 PATIENT NAME RECIPIENT, I.M.A.						13 PATIENT ADDRESS																		
14 BIRTHDATE		15 SEX	16 MS	17 DATE		ADMISSION 18 HR		19 TYPE	20 SRC		21 D HR	22 STAT	23 MEDICAL RECORD NO. 03 7654321		24		CONDITION CODES 25		26	27	28	29	30	31
32 OCCURRENCE DATE		33		34 OCCURRENCE DATE		35		36 OCCURRENCE SPAN FROM		37 THROUGH		38	39	40	41	42	43	44	45	46	47	48	49	50
39 CODE		40		41 CODE		42		43 VALUE CODES AMOUNT		44		45		46		47		48		49		50		51
42 REV. CD.	43 DESCRIPTION			44 HCPCS / RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49												
1	0550	MMDDYY			99504 TD UG			9.5	XXX XX			1												
2	0550	MMDDYY			99504 TD UG			9.5	XXX XX			2												
3	0550	MMDDYY			99504 TD UG			6.0	XXX XX			3												
4	0550	MMDDYY, MMDD, MMDD, MMDD			99504 TD UG			24.0	XXX XX			4												
5	0001	TOTAL CHARGES							XXXX XX			5												
6												6												
7												7												
8												8												
9												9												
10												10												
11												11												
12												12												
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19												19												
20												20												
21												21												
22												22												
23												23												
50 PAYER T19 MEDICAID				51 PROVIDER NO. 87654321				52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST AMOUNT DUE		56										
DUED FROM PATIENT ▶												57												
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. V461		68 CODE		69 CODE		70 CODE		OTHER DIAG. CODES 71 CODE		72 CODE		73 CODE	74 CODE	75 ADM DIAG CD.	76 E-CODE	77	78							
79 P.C.	80	PRINCIPAL PROCEDURE CODE	DATE	81	OTHER PROCEDURE CODE	DATE	82	ATTENDING PHYS. ID 12345678 I.M. ATTENDING				83	OTHER PHYS. ID											
84	REMARKS	85	OTHER PROCEDURE CODE	DATE	86	OTHER PROCEDURE CODE	DATE	87	OTHER PHYS. ID				88	OTHER PHYS. ID										
85	PROVIDER REPRESENTATIVE X I.M. Provider	86	DATE MMDDYY	87	OTHER PHYS. ID	88	OTHER PHYS. ID	89	OTHER PHYS. ID				90	OTHER PHYS. ID										

ATTACHMENT 10

Prior Authorization Request Form (PA/RF) Completion Instructions for home 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 and the physician's plan of care, along with all applicable service-specific attachments including the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) for home health providers or the Respiratory Care Services/Plan of Care (RCS/POC) for RCS providers, 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 Home Health/Home Health Therapy/RCS. 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 correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION**Element 5 — Recipient Medicaid ID Number**

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

Element 6 — Date of Birth — Recipient

Enter the recipient’s date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient

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

Element 8 — Name — Recipient

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

Element 9 — Sex — Recipient

Enter an “X” in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION**Element 10 — Diagnosis — Primary Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

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) 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 modifiers if appropriate for the procedure code listed in Attachment 1. Do not list start-of-shift modifiers.

Element 18 — POS

Enter the appropriate place(s) of service (POS) code designating where the requested service/procedure would be provided/performed. Refer to Attachment 3 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate CPT or HCPCS procedure code for each service/procedure requested. Indicate in the description the credentials of the individual who provided the service (e.g., licensed practical nurse, registered nurse, respiratory therapist).

When requesting skilled nursing, home health aide, or therapy indicate the number of visits per day multiplied by the number of days per week, multiplied by the total number of weeks being requested.

When requesting RCS or private duty nursing, indicate the number of hours per day multiplied by the number of days per week, multiplied by the total number of weeks being requested.

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. When requesting two procedure codes to be used interchangeably, include a statement that the total number of hours will not exceed the combined total number of hours ordered on the physician’s plan of care. When requesting permission to bill for multiple visits when only one visit is provided, enter “Authorization requested to bill for (number of) subsequent Home Health Aide visits to do (number of) continuous hours 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/procedure requested. If the quantity is greater than “1.0,” multiply the quantity by the charge for each service/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 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 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 11

Sample Prior Authorization Request Form (PA/RF) for skilled nursing and aide services

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

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

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN		AT	Prior Authorization Number			
SECTION I — PROVIDER INFORMATION						
1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Provider 1 W. Williams Anytown, WI 55555		2. Telephone Number — Billing Provider (XXX) XXX-XXXX		3. Processing Type 120		
		4. Billing Provider's Medicaid Provider Number 12345678				
SECTION II — RECIPIENT INFORMATION						
5. Recipient Medicaid ID Number 1234567890		6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY		7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555		
8. Name — Recipient (Last, First, Middle Initial) Recipient, I m A.			9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F			
SECTION III — DIAGNOSIS / TREATMENT INFORMATION						
10. Diagnosis — Primary Code and Description 250.0 — Diabetes II (NIDDM)			11. Start Date — SOI	12. First Date of Treatment — SOI		
13. Diagnosis — Secondary Code and Description 401.9 — Hypertension NOS			14. Requested Start Date MM/DD/YY			
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4	18. POS	19. Description of Service	20. QR	21. Charge
	99600		12	HHN — initial visit 1 visit/day x 3 days/wk x 29 weeks	87	XXX.XX
	T1021		12	HHA — initial visit 1 visit/day x 7 days/week x 29 weeks	203	XXX.XX
	99600	TS	12	HHN — follow-up visit 1 visit/day x 3 days/wk x 29 weeks	87	XXX.XX
	T1021	TS	12	HHA — follow-up visit 1 visit/day x 7 days/week x 29 weeks	203	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 <div style="text-align: center;"><i>I.M. Provider</i></div>					24. Date Signed MM/DD/YY	
FOR MEDICAID USE			Procedure(s) Authorized:		Quantity Authorized:	
<input type="checkbox"/> Approved <div style="display: flex; justify-content: space-around; width: 100%;"> 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 12

Sample Prior Authorization Request Form (PA/RF) for home health therapy services

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

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

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
-------------------------------	----	----------------------------

SECTION I — PROVIDER INFORMATION		
1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Provider 1 W. Williams Anytown, WI 55555	2. Telephone Number — Billing Provider (XXX) XXX-XXXX	3. Processing Type 120
	4. Billing Provider's Medicaid Provider Number 12345678	

SECTION II — RECIPIENT INFORMATION		
5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.	9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION						
10. Diagnosis — Primary Code and Description 429.2 — CVA				11. Start Date — SOI		12. First Date of Treatment — SOI
13. Diagnosis — Secondary Code and Description 250.0 — Diabetes II (NIDDM)				14. Requested Start Date MM/DD/YY		
15. Performing Provider Number	16. Procedure Code	17. Modifiers	18. POS	19. Description of Service	20. QR	21. Charge
	97799	1 2 3 4	12	HH-physical therapy 1 visit/day x 3 days/wk x 26 wks	78 visits	X,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.

23. SIGNATURE — Requesting Provider <div style="text-align: center;"><i>I.M. Provider</i></div>	24. Date Signed MM/DD/YY
--	------------------------------------

FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved	_____	_____
	Grant Date	Expiration Date
<input type="checkbox"/> Modified — Reason:	_____	
<input type="checkbox"/> Denied — Reason:	_____	
<input type="checkbox"/> Returned — Reason:	_____	
	SIGNATURE — Consultant / Analyst	Date Signed

ATTACHMENT 13

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.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
-------------------------------	----	----------------------------

SECTION I — PROVIDER INFORMATION		
1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Provider 1 W. Williams Anytown, WI 55555	2. Telephone Number — Billing Provider (XXX) XXX-XXXX	3. Processing Type 120
4. Billing Provider's Medicaid Provider Number 12345678		

SECTION II — RECIPIENT INFORMATION		
5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.	9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION						
10. Diagnosis — Primary Code and Description V46.1 — Ventilator		11. Start Date — SOI	12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description 344.0 — Quadriplegia		14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers	18. POS	19. Description of Service	20. QR	21. Charge
	99504	TD	12, 99	RCS-HH/RN 12°/d, 7d/wk x 53 wk	4,452 hrs	XX,XXX.XX
	99504	TE	12, 99	RCS-HH/LPN 12°/d, 7d/wk x 53 wk	4,452 hrs	XX,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.

23. SIGNATURE — Requesting Provider <div style="text-align: center; font-family: cursive; font-size: 1.2em;">I.M. Provider</div>	24. Date Signed MM/DD/YY
---	------------------------------------

FOR MEDICAID USE	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 14

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.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
-------------------------------	----	----------------------------

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Provider 1 W. Williams Anytown, WI 55555	2. Telephone Number — Billing Provider (XXX) XXX-XXXX	3. Processing Type 120
4. Billing Provider's Medicaid Provider Number 12345678		

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description 770.7 — Bronchopulmonary dysplasia					11. Start Date — SOI		12. First Date of Treatment — SOI		
13. Diagnosis — Secondary Code and Description 343.9 — Infantile cerebral palsy					14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
	S9124	1	2	3	4	12, 99	PDN/RN 12 hours/d, 7 day/wk x 53 wk	4,452 hrs	XX,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.

23. SIGNATURE — Requesting Provider <i>I.M. Provider</i>	24. Date Signed MM/DD/YY
---	------------------------------------

FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:		
<input type="checkbox"/> Approved <table style="width: 100%; margin-left: 100px;"> <tr> <td style="width: 50%; text-align: center;">Grant Date</td> <td style="width: 50%; text-align: center;">Expiration Date</td> </tr> </table>			Grant Date	Expiration Date
Grant Date	Expiration Date			
<input type="checkbox"/> Modified — Reason:				
<input type="checkbox"/> Denied — Reason:				
<input type="checkbox"/> Returned — Reason:				
SIGNATURE — Consultant / Analyst		Date Signed		

ATTACHMENT 15

Prior Authorization / Home Health Therapy Attachment (PA/HHTA) Completion Instructions

(A copy of the "Prior Authorization/Home Health Therapy Attachment [PA/HHTA] Completion Instructions" is located on the following pages.)

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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)
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/Home Health Therapy Attachment (PA/HHTA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid at the address listed below. If other home health services (e.g., nursing, aide services) are being provided in addition to home health therapy services, complete this attachment form and submit it with the appropriate forms for the other services. 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 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's ten-digit Medicaid identification number as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist

Enter the name and credentials of the primary therapist who would be responsible for and participate in home health therapy services for the recipient. If the performing provider would be a certified therapy assistant, enter the name of the certified therapist who will be physically present at the residence to supervise the certified therapy assistant.

Element 5 — Therapist's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the Medicaid provider number of the supervising therapist. *If the therapist does not have a provider and is employed by or under contract to the agency, enter the agency's Medicaid provider number.*

Element 6 — Telephone Number — Therapist

Enter the telephone number, including the area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring / Prescribing Physician

Enter the name of the physician referring/prescribing home health therapy evaluation and/or treatment.

Element 8 — Referring / Prescribing Physician's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the physician referring/prescribing home health therapy services.

The remaining portions of this attachment are to be used to document the justification of home health therapy services.

SECTION III — DOCUMENTATION

Complete Elements 9 through 17. The provider may refer to specific sections of the attachments rather than duplicating information. For example, the provider may indicate on the attachment, "Refer to item #3 of therapy evaluation."

Element 9

Provide a brief history pertinent to the service(s) requested.

Element 10

Provide a description of the recipient's diagnosis and problems as they pertain to the need for the therapy services requested. Include the date of onset.

Element 11

State therapy history. Include type/date/location for all types of therapy.

Element 12

Indicate the date of initial evaluation. Supply dates/tests/results of additional evaluations.

Element 13

Describe progress in measurable/functional terms since treatment was initiated or last authorized.

Element 14

Attach a Plan of Care indicating specific, measurable goals and procedures to meet those goals.

Element 15

Describe rehabilitation potential.

Element 16 — Signature — Requesting Provider

Wisconsin Medicaid requires the requesting provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 17 — Date Signed

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

Other Required Information

1. Attach a copy of the Physician's Plan of Care.
2. Attach a copy of the therapy evaluation.
3. If the request is for a recipient under age 22, attach a copy of the Individualized Education Program or explain why there is none.
4. If the request is for a child under age 3, attach a copy of the Individual Family Service Plan or explain why there is none.

ATTACHMENT 16
Prior Authorization / Home Health Therapy Attachment
(PA/HHTA) (for photocopying)

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

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)

Providers may submit prior authorization 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/Home Health Therapy Attachment (PA/HHTA) Completion Instructions (HCF 11044A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist

5. Therapist's Medicaid Provider Number

6. Telephone Number — Therapist

7. Name — Referring / Prescribing Physician

8. Referring / Prescribing Physician's Medicaid Provider Number

SECTION III — DOCUMENTATION

9. Provide a Brief History Pertinent to the Service(s) Requested

10. Provide a Description of the Recipient's Diagnosis and Problems As They Pertain to the Need for the Therapy Services Requested (Include the date of onset)

SECTION III — DOCUMENTATION (Continued)

11. State Therapy History (Indicate type / date / location for all types of therapy)

Service Area	Location	Date	Problem Treated
Physical Therapy			
Occupational Therapy			
Speech and Language Pathology			

12. Indicate the Date of Initial Evaluation (Supply dates / tests used / results of additional evaluations)

13. Describe Progress in Measurable / Functional Terms Since Treatment Was Initiated or Last Authorized

14. Attach a Plan of Care Indicating Specific, Measurable Goals and Procedures to Meet Those Goals

15. Describe Rehabilitation Potential

16. **SIGNATURE** — Requesting Provider

17. Date Signed

ATTACHMENT 17
Respiratory Care Services / Plan of Care (RCS/POC)
Completion Instructions

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

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**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 18
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).

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

SECTION II — RESPIRATORY CARE SERVICES REQUIRED		
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		
List scope of at least three parameters to be monitored for recipient (e.g., vital signs, breath sounds, secretions)	Times per 24-hour period parameter assessment completed	Comments
1.		
2.		
3.		
4.		
5.		
6.		

Continued

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

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? Yes No

Case coordinator has been designated? Yes No

I am the case coordinator. Yes No (name of case coordinator) _____

Describe other pertinent respiratory care needs below.

List any other comments below.

SIGNATURE — Nurse	Position Title	Date Signed
SIGNATURE — Physician	Position Title	Date Signed

ATTACHMENT 19

Prior Authorization Amendment Request Completion Instructions

(A copy of the "Prior Authorization Amendment Request Completion Instructions" 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 20
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. SIGNATURE — Requesting Provider	12. Date Signed
--	-----------------

ATTACHMENT 21
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)
------------------------------------	--

SIGNATURE

Date Signed

Check one:

- Recipient
- Recipient's Parent
- Guardian
- Legal Representative