This **Update** has been revised since its original publication. Elements 13 and 14 of the form are now optional. See Attachment 2 for a revised version of the form.

ForwardHealth
Wisconsin serving you

Update
May 2009

No. 2009-28

Affected Programs: BadgerCare Plus, Medicaid
To: Nurse Midwives, Nurse Practitioners, Physician Clinics, Physicians, Specialized Medical Vehicle Providers, HMOs and Other Managed Care Programs

ForwardHealth Announces Revisions to the Certification of Need for Specialized Medical Vehicle Transportation Form and Completion Instructions

The Certification of Need for Specialized Medical Vehicle Transportation form, F-1197 (06/09), and the completion instructions have been revised. Effective immediately, providers are required to use the revised form attached to this *ForwardHealth Update*.

Effective immediately, providers will be required to use the revised Certification of Need for Specialized Medical Vehicle Transportation form, F-1197 (06/09), and completion instructions. The following changes were made:

- Element 12 of the form has been modified. Providers are now required to enter the National Provider Identifier of the medical care provider in this element.
- Terminology has been updated on the form and completion instructions for the implementation of ForwardHealth interChange.

Refer to Attachments 1 and 2 of this *ForwardHealth Update* for copies of the Certification of Need for Specialized Medical Vehicle Transportation form and completion instructions. Providers do not need to complete a revised Certification of Need for Specialized Medical Vehicle Transportation form for members who are currently certified for specialized medical vehicle transportation. Current Certification of Need for Specialized Medical Vehicle Transportation forms will be valid until the current certification expires.

The information in this *Update* applies to Wisconsin Medicaid and the BadgerCare Plus Standard Plan.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions

(A copy of the "Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions" is located on the following page.)

WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the program to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth 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 enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

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

The use of this form is mandatory. ForwardHealth will not accept alternate versions of this form. Completed forms that appear to be altered in ***any way*** will not be accepted. For further instructions or questions, refer to the ForwardHealth Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* or contact Provider Services at (800) 947-9627.

INSTRUCTIONS — SPECIALIZED MEDICAL VEHICLE PROVIDER

1. Give a copy of this form to the member requesting specialized medical vehicle (SMV) transportation for his or her medical care provider (evaluator) to complete if he or she does not already have a copy. ForwardHealth will not accept alternate versions of this form. Completed forms that appear to be altered in ***any way*** will not be accepted. The form is valid only if every element is completed and has the evaluating medical provider's original signature (i.e., not a stamped or photocopied signature.) ForwardHealth will not accept incomplete forms or forms without original signatures. Faxes or copies from the medical care provider are acceptable as long as they are legible and the origin and the traveling path of the form can be clearly identified. ForwardHealth will not accept illegible faxes or copies.

2. Accept the form only if the date of receipt is within 14 working days from the date the medical care provider (evaluator) signs the form. If the form indicates that the member is temporarily disabled, the certification of need is valid for the period indicated on the form in Element 4. This period must be no more than 90 days from the date the medical care provider signed the form. If the form indicates that the member is indefinitely disabled or legally blind, the certification of need is valid for three years (36 months) from the date the medical care provider (evaluator) signed the form.

3. Retain the completed original in the member's file for five years from the last date of service billed under this form. Failure to retain this form may result in recovery of payment for the SMV services provided to the member.

INSTRUCTIONS — MEDICAL CARE PROVIDER (EVALUATOR) COMPLETING FORM

Type or print clearly.

Section I
Enter the member's full name and member ID; including a middle initial is optional. The date of birth is also optional.

Section II
Determine whether or not the member has a condition that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle. If not, ***stop*** here and refer the member to the transportation coordinator at his or her local county or tribal agency. If yes, complete Sections III and IV.

Sections III and IV
Complete Sections III and IV if the member's condition contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle. Sign and date Section IV only if the medical provider (physician, physician assistant, nurse midwife, or nurse practitioner) has evaluated this member and finds that he or she is legally blind or disabled and cannot travel safely by common carrier, such as a private vehicle or accessible mass transit. The provider's signature must be original and cannot be stamped or photocopied. Give the original form to the member and keep a copy.

Definitions

Indefinitely Disabled — As stated in DHS 107.23(1)(c)1, Wis. Admin. Code, "indefinitely disabled" means a chronic, debilitating physical impairment which includes an inability to ambulate without personal assistance or requires the use of a mechanical aid such as a wheelchair, a walker or crutches, or a mental impairment which includes an inability to reliably and safely use common carrier transportation because of organic conditions affecting cognitive abilities or psychiatric symptoms that interfere with the recipient's safety or that might result in unsafe or unpredictable behavior. These symptoms and behaviors may include the inability to remain oriented to correct embarkation and debarkation points and times and the inability to remain safely seated in a common carrier cab or coach.

Temporarily Disabled — A condition that meets the above definition but is expected to exist only for a limited time.

ATTACHMENT 2
Certification of Need for Specialized Medical Vehicle Transportation

(A copy of the "Certification of Need for Specialized Medical Vehicle Transportation" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-1197 (06/09)

STATE OF WISCONSIN

WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

Instructions: Type or print clearly. All areas of this form must be completed and signed by a medical care provider (evaluator) to verify the need for specialized medical vehicle (SMV) transportation. Only a physician, physician assistant, nurse midwife, or nurse practitioner may be an evaluator and sign this form. Refer to the Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions, F-1197A, for information on completing this form.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Member Identification Number	3. Member's Date of Birth (MM/DD/YY) (Optional)

SECTION II — ELIGIBILITY FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

4. Does the member have a physical / mental impairment that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle?

   If "**no**," then **STOP** here. Do **not** complete or sign this form. Instead, refer the member to the Medicaid transportation coordinator at his or her local county or tribal agency.

   If "**yes**," then complete Sections III and IV of this form.

SECTION III — DIAGNOSIS INFORMATION AND VERIFICATION OF MEDICAL CONDITION

5. I have evaluated this member and certify that he or she is one of the following. (Refer to the completion instructions of this form for definitions of indefinitely and temporarily disabled.) (Check one.)

   ❑ Indefinitely disabled. This form is valid for three years (36 months) from the date signed by the medical care provider.

   ❑ Legally blind. This form is valid for three years (36 months) from the date signed by the medical care provider.

   ❑ Temporarily disabled. This form is valid for no more than 90 days from the date signed by the medical care provider. (This certification of need may be renewed after 90 days, if necessary.)

   If less than 90 days, state expected duration of disability: _____ days

6. Does the member require the use of a wheelchair or scooter?

   ❑ Yes ❑ No

7. The evaluating medical provider is required to explain in the space provided why the member's physical / mental condition requires transportation in an SMV and why the member cannot access mass transit, taxi, or a private vehicle. Include the diagnosis, if possible.

SECTION IV — MEDICAL CARE PROVIDER (EVALUATOR) INFORMATION

I, the medical provider (physician, physician assistant, nurse midwife, or nurse practitioner), have evaluated this member and certify that he or she has a condition that contraindicates safe travel by common carrier, such as private vehicles or mass-transit services, and requires the use of an SMV for transportation to receive medical services.

8. **SIGNATURE** — Evaluator		9. Date Signed — Evaluator
10. Name — Evaluator (Print)		11. Position Title — Evaluator
12. National Provider Identifier	13. Taxonomy Number (Optional)	14. Practice Location ZIP+4 Code (Optional)