
WISCONSIN MEDICAID UPDATE

MAY 26, 1995

UPDATE 95-16

TO:
Nurse Midwives
Nurse Practitioners
Physicians
Physician Assistants

Transportation Policy Changes Affect Referring Providers

Wisconsin Medicaid Transportation Covered Services

Wisconsin Medicaid covers necessary transportation to and from Wisconsin Medicaid-covered services. County human services departments and tribal agencies approve and pay for common carrier transportation by car, bus, or taxi. Wisconsin Medicaid covers Specialized Medical Vehicle (SMV) transportation for recipients who are temporarily or indefinitely physically or mentally disabled with conditions that contraindicate common carrier transportation. A physician, physician assistant, nurse midwife, or nurse practitioner must complete a Physician Certification Form certifying the disability for recipients to use SMV transportation.

Wisconsin Medicaid Changes in SMV Coverage Affect Referring Providers

In order to reduce the costly and inappropriate use of SMVs by recipients, the Legislature adopted changes in HSS 107.23, Wis. Admin. Code, effective December 1, 1994. Three of the changes affect physicians, physician clinics, physician assistants, nurse practitioners, and nurse midwives:

- ♦ effective December 1, 1994, Physician Certification Forms may be signed by

physician assistants and nurse midwives, as well as physicians and nurse practitioners

- ♦ effective April 1, 1995, indefinitely disabled recipients' Physician Certification Forms are no longer permanent and must be renewed annually
- ♦ effective June 1, 1995, a prescription, in addition to the Physician Certification Form, is required for SMV trips to Wisconsin Medicaid-covered services that exceed upper mileage limits

Physician Certification Form

Policy

In order to be eligible for SMV services, a recipient must give the SMV provider a signed and dated Physician Certification Form. The form certifies to SMV providers that a recipient is eligible for SMV transportation.

You do not need to keep a copy of the completed form on file, but you must document in the recipient's records the medical condition that requires SMV transportation.

Form Requirements

A copy of the Physician Certification Form is included with this *Wisconsin Medicaid Update*. Please complete a copy of this form to give to recipients whom you certify as needing SMV transportation.

The form must identify:

- ♦ the recipient's specific medical problem
- ♦ why the recipient's condition contraindicates common carrier transport
- ♦ the length of time SMV transportation is needed. Wisconsin Medicaid's maximum is up to 90 days for a temporary disability and 365 days for indefinite disability

You may not charge the recipient for completing the form. Wisconsin Medicaid covers the lowest level evaluation and management procedure if the recipient is in the office when the form is completed and no other medical service is provided except the evaluation for SMV transportation.

Prescriptions Now Required For SMV Trips That Exceed One-Way Upper Mileage Limits

Effective June 1, 1995, Wisconsin Medicaid requires a prescription for SMV trips that exceed established one-way upper mileage limits (except for hospital or nursing home discharges). Recipients will no longer be provided trips to distant medical services without a prescription. If you refer a recipient who needs SMV transportation to a medical service that

you suspect is farther away than the one-way upper mileage limits, write a prescription for the recipient to show the SMV provider. SMV providers cannot transport recipients to health care services beyond the upper mileage limits without a prescription. SMV providers need the prescription to get prior authorization to exceed upper mileage limits.

Wisconsin Medicaid one-way upper mileage limits are:

- ♦ **40 miles**, if the trip originates in one of these urban counties:

Brown	Dane
Fond du Lac	Kenosha
LaCrosse	Manitowoc
Milwaukee	Outagamie
Sheboygan	Racine
Rock	Winnebago
- ♦ **70 miles**, if the trip originates in *any other* Wisconsin county.

The prescription must include the name of the provider receiving the referral, the city where the provider is located, the service required, and the amount of time the recipient needs transportation. Indicate the duration of the prescription in days, not to exceed 365 days.

Here is an example of an SMV trip prescription:

Providers who may refer recipients and write SMV prescriptions for extended mileage trips are: physicians, physician assistants, nurse midwives, nurse practitioners, dentists, optometrists, opticians, chiropractors, podiatrists, HealthCheck agencies, and family planning clinics.

Anytown Clinic
1 W. Wilson
Anytown, WI 55555

Name J. M. Recipient

Address 609 Willow, Anytown, WI 55555

Rx Regional Clinic, Green Bay
Radiation Therapy
120 Days

Prescriber's
Signature J. M. Referring M.D. Date 6/1/95

**SMV TRANSPORTATION
 PHYSICIAN CERTIFICATION**

This form must be completed by a physician, physician assistant, nurse midwife or nurse practitioner in order for SMV transportation to be reimbursed by the Wisconsin Medical Assistance Program.

I, _____, have evaluated _____, (print name) _____ (recipient's name) _____ (MA ID number) _____ on _____ (date) _____ and certify that he/she requires the use of a specialized medical vehicle (SMV) for transportation to receive medical services and is unable to manage available transportation by common carrier (e.g., car, taxi, bus). The recipient has the following medical diagnosis/problems which contribute to the need for SMV transportation. Please list the diagnosis/problems and the ICD-9-CM code. (ICD-9-CM code is optional.)

Diagnosis/Problem	ICD Code	Please describe how diagnoses/problems necessitate the need for SMV transportation:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please identify whether the recipient's disability is indefinite or temporary (check one). _____ indefinite _____ temporary
 If temporary, specify expected number of months to resolution of condition/problem. _____ months

A recipient must have both a medical diagnosis/problem and a level of assistance diagnosis need to receive SMV transportation.
 Please circle all of the following that describe the recipient's level of assistance requirements.

A11 Cot/Stretcher (must have help)	D11 Behavior/Cognitive Problem (must have help)
B11 Wheelchair	D21 Behavior/Cognitive Problem (moderate help)
C11 Cane/Crutches/Walker/Low Staminator/ Unsteady Gait (must have help)	D31 Behavior/Cognitive Problem (minimal help)
C21 Cane/Crutches/Walker/Low Staminator/ Unsteady Gait (moderate help)	G11 Hospital/Nursing Home Discharge
C31 Cane/Crutches/Walker/Low Staminator/ Unsteady Gait (minimal help)	

 (signature) _____ (date) _____ (UPIN or MA Provider number)