wisconsin Medicaid update
department of health and family services
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To:
HMOs and Other Managed Care Programs
Nurse Midwives
Nurse Practitioners
Physician Assistants
Physicians
SMV Providers

SMV Transportation Physician Certification form revised

Enclosed is the new Specialized Medical Vehicle (SMV) Transportation Physician Certification form. This form is used to authorize SMV services for Medicaid recipients who require a ramp or lift-equipped vehicle. This form is required for fee-for-service recipients; however, HMOs may require the use of this form also.

This version replaces the certification form that appears as Appendix 35 in Part K, the physician handbook; as Appendix 14 in Part T, Division II, the nurse practitioner handbook; and in the reproducible forms section of Part Q, Division II, the SMV handbook.

Providers are required to use the new version of the physician certification form beginning no later than December 1, 1998.

Form effective December 1, 1998

Providers are required to use the new version of the physician certification form beginning no later than December 1, 1998.

Providers do not need to redo or transfer existing certifications to this new form until their existing certification is due to be renewed.

Allowable medical providers who may complete the form

Wisconsin Medicaid allows the following medical providers to authorize SMV transportation services by completing the certification form:

- Physicians.
- Physician assistants.
- Nurse midwives.
- Nurse practitioners.

Purpose of the form

The purpose of this form is to verify that, in the judgement of a medical professional, the Medicaid recipient being transported by SMV truly requires a ramp or lift-equipped vehicle.

When the recipient is able to safely use an automobile, bus, or taxi, medical providers should refer the recipient to the appropriate county, social or human service department or tribal agency for common carrier transportation instead of authorizing SMV transportation.

Form changes

- A space was added at the top left to allow SMV providers to add their company's name and address if they choose to do so.
- Allowable medical providers must now complete *all areas* in the main body of the form.
- Allowable medical providers are instructed to complete this form only if the recipient requires a ramp or lift-equipped vehicle.
- A space has been added for the recipient's date of birth.

- *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) code is now required, rather than optional.

- More space has been added for the allowable medical provider to describe how the recipient's diagnoses/problems justify the need for SMV transportation.

  It is critical that physicians, physician assistants, nurse midwives, and nurse practitioners *complete this section clearly and carefully* to fully document why the recipient must use a ramp or lift-equipped vehicle.

- Instructions for the level of assistance have been changed. Providers should now select only the highest degree of assistance necessary rather than all levels of assistance.

- For certification of an indefinite disability, a statement has been added explaining that *SMV certification for recipients must be renewed annually*. While this has always been the case, it was not previously specified on the form.

- For certification of a temporary disability, the allowable medical provider must now specify temporary disability in days, rather than months.

When the recipient is able to safely use an automobile, bus, or taxi, medical providers should refer the recipient to the appropriate county, social or human service department or tribal agency for common carrier transportation instead of authorizing SMV transportation.

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

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

For provider questions, call the Medicaid fiscal agent, EDS, at (800) 947-9627 or (608) 221-9883.

SMV Company name and address may be entered in the space below:

HFS 107.23 Wis. Admin. Code

SMV TRANSPORTATION
PHYSICIAN CERTIFICATION

All areas of this form must be completed by a physician, physician assistant, nurse midwife or nurse practitioner to justify the need for SMV transportation.

Please complete this form **only** if the Medicaid recipient is legally blind or disabled to the extent that he/she cannot safely use private vehicles or mass transit services. *Refer recipients who can safely travel in an automobile, taxi, or bus to the Medicaid transportation coordinator in their tribal agency or county human or social services department.*

I, _____ have evaluated _____ _____ _____

(Certifying Provider's name) (Recipient's Name) (Date of Birth) (Medicaid ID Number)

on _____ 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 diagnoses/problems which justify the need for SMV transportation.

(Date)

Diagnosis/Problem	**ICD-9-CM Code**	**Describe how diagnosis/problem necessitates the need for SMV services**

Select one or some (but not all) of the following that describe the recipient's level of assistance requirements:

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

I certify the recipient's disability is indefinite or temporary (check one).

Indefinite ☐ (Certification must be renewed yearly.)

Temporary ☐

If temporary, specify expected number of days to resolution of condition/problem:

Days _____ (Maximum 90 days)

_____ _____ _____

(Signature) (Date) (UPIN or Medicaid Provider Number)