

# Chiropractic Services

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Wisconsin  
**Medicaid**  
and BadgerCare  
Information for Providers  
Department of Health and Family Services



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Governor

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**State of Wisconsin**

**Department of Health and Family Services**

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**DATE:** October 1, 2004

**TO:** Wisconsin Medicaid-certified chiropractic providers

**FROM:** Mark Moody, Administrator   
Division of Health Care Financing

**SUBJECT:** Wisconsin Medicaid **Chiropractic Services Handbook**

The Division of Health Care Financing (DHCF) is pleased to provide you with a copy of the new Chiropractic Services Handbook. This handbook articulates current Medicaid policies found in the Wisconsin Administrative Code, HFS 101-108, as they apply to chiropractic services.

We would like to thank everyone who spent time reviewing and commenting on this handbook as those suggestions helped shape the final product.

The Chiropractic Services Handbook incorporates current Medicaid chiropractic policy information into a single reference source. The handbook replaces the Chiropractic Services Handbook, dated June 1995, and all chiropractic services *Wisconsin Medicaid and BadgerCare Updates*.

This handbook does *not* replace the All-Provider Handbook and all-provider *Updates*, the Wisconsin Administrative Code, or Wisconsin Statutes. Subsequent changes to chiropractic policies will be published first in *Updates* and later in the Chiropractic Services Handbook revisions.

**Additional Copies of Publications**

All *Updates* and the Chiropractic Services Handbook can be downloaded from the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

If you have questions about the information in this handbook, please contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Thank you for providing Medicaid chiropractic services.

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# Preface

The Wisconsin Medicaid and BadgerCare Chiropractic Services Handbook is issued to chiropractors who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2004, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185 percent of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

## Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways. Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

## Handbook Organization

The Chiropractic Services Handbook consists of the following chapters:

- General Information.
- Covered Services.
- Prior Authorization.
- Claims Submission.

In addition to the Chiropractic Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

## Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

### Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

## Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin

Medicaid and BadgerCare are available at the following Web sites:

[dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/)  
[dhfs.wisconsin.gov/badgercare/](http://dhfs.wisconsin.gov/badgercare/)

## Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

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# General Information

The Chiropractic Services Handbook includes information for Wisconsin Medicaid-certified chiropractors about covered services, prior authorization (PA) requirements, and claims submission requirements.

For more information about chiropractic services, including publications that may be downloaded, such as *Wisconsin Medicaid and BadgerCare Updates*, go to the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

## Provider Information

### Scope of Service

The policies in the Chiropractic Services Handbook govern services provided within the scope of the profession's practice as defined in the Wisconsin Statutes and the Wisconsin Administrative Code.

### Eligibility and Certification

Under HFS 105.26, Wis. Admin. Code, chiropractors are required to be licensed by the Wisconsin Chiropractic Examining Board according to s. 446.02, Wis. Stats., for Wisconsin Medicaid certification.

For general information on applying for Wisconsin Medicaid certification, please refer to the Provider Certification section of the All-Provider Handbook. Providers may also download certification packets from the Wisconsin Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

### Certification for Laboratory Services

All laboratories testing human specimens to determine health status are covered by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Lab operations governed by CLIA include the following:

- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Tests performed.

All providers performing laboratory tests need a CLIA identification number and a certificate of waiver or certificate of registration from the federal Centers for Medicare and Medicaid Services (CMS). This applies to clinics and individual provider offices that perform lab tests.

Clinics with multiple-location labs are required to have a billing provider number for each lab with a CLIA identification number.

A lab may receive a certificate of waiver if it restricts testing of waived tests as identified by the CMS. A lab that performs more than the waived tests needs a certificate of registration.

### Provider Responsibilities

Detailed information about the responsibilities of a Medicaid-certified provider can be found in the Provider Rights and Responsibilities section of the All-Provider Handbook. Refer to that section for information about the following:

- Additional state and federal requirements.
- Fair treatment of the recipient.
- Grounds for provider sanctions.
- Recipient requests for noncovered services.
- Services provided to a recipient during periods of retroactive eligibility.

For more information about chiropractic services, including publications that may be downloaded, such as *Wisconsin Medicaid and BadgerCare Updates*, go to the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

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## Recipient Information

### Verifying Recipient Eligibility

Wisconsin Medicaid providers should verify recipient eligibility and identify any limitations to the recipient's coverage *before* providing services.

Recipients in the following benefit categories have limitations in their Medicaid coverage:

- Family Planning Waiver Program.
- Illegal (undocumented) aliens. (Refer to the Physician Services Handbook for a reproducible copy of the Certification of Emergency for Non-U.S. Citizens form, HCF 1162.)
- Presumptive Eligibility for Pregnant Women Program.
- Qualified Medicare Beneficiary only.
- Qualified Working Disabled Individual.
- SeniorCare.
- Specified Low-Income Medicare Beneficiary only.
- Tuberculosis-related.

Eligibility information for specific recipients is available from Wisconsin Medicaid's Eligibility Verification System (EVS). The EVS is used by providers to verify recipient eligibility, including whether the recipient is enrolled in a Medicaid HMO, has commercial health insurance coverage, or is in a restricted benefit category. Providers can access Medicaid's EVS a number of ways, including:

- Automated Voice Response system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services.
- Direct Information Access Line with Updates for Providers (Dial-Up).

Refer to the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/) for more information about these restricted benefit

categories and ways to verify recipient eligibility. For telephone numbers regarding recipient eligibility, refer to the page of Important Telephone Numbers at the beginning of this handbook.

### Transportation to Medical Appointments

Medicaid-eligible recipients may use specialized medical vehicle (SMV) transportation to receive chiropractic services. If a recipient has a disability or a condition that contraindicates common carrier transportation, a physician, physician assistant, nurse midwife, or nurse practitioner is required to complete a Certification of Need for Specialized Medical Vehicle Transportation form, HCF 1197, to certify the recipient's coverage for SMV transportation.

The medical provider gives the completed form to the recipient who then gives the form to the SMV provider.

#### *Specialized Medical Vehicle Trips Exceeding One-Way Upper Mileage Limits*

Wisconsin Medicaid requires a prescription for SMV trips that exceed Wisconsin Medicaid's one-way mileage limits.

This prescription is required in addition to the Certification of Need for Specialized Medical Vehicle Transportation form. The prescription must be renewed upon expiration and must include the following:

- Name of the health care provider or facility and the city in which the provider or facility is located.
- The service being provided.
- The length of time the recipient will need the service (not to exceed 365 days).

A provider, such as a chiropractor, referring an SMV-eligible recipient to a Medicaid-covered health service that is farther than the upper mileage limit is required to write a prescription

**W**isconsin Medicaid providers should verify recipient eligibility and identify any limitations to the recipient's coverage *before* providing services.



All providers who provide a service that requires a recipient copayment are required to make a reasonable attempt to collect that copayment from the recipient.

for the recipient to give to the SMV provider. The SMV provider uses the prescription to obtain PA for SMV trips exceeding one-way upper mileage limits.

Wisconsin Medicaid one-way upper mileage limits are:

- 40 miles or more, if the trip originates in one of these urban counties:
  - ✓ Brown.
  - ✓ Dane.
  - ✓ Fond du Lac.
  - ✓ Kenosha.
  - ✓ La Crosse.
  - ✓ Manitowoc.
  - ✓ Milwaukee.
  - ✓ Outagamie.
  - ✓ Racine.
  - ✓ Rock.
  - ✓ Sheboygan.
  - ✓ Winnebago.
- 70 miles or more, if the trip originates in *any other* Wisconsin county.

## Copayment

### Copayment Amounts

Copayment amounts are determined per procedure code per date of service (DOS) as follows.

Copayment Amounts*	
<i>Maximum Allowable Fee</i>	<i>Copayment</i>
• Up to \$10.00	\$0.50
• From \$10.01 to \$25.00	\$1.00
• From \$25.01 to \$50.00	\$2.00
• Over \$50.00	\$3.00

\*Copayment amounts are based on the maximum allowable fee for each procedure code.

Maximum allowable fee schedules list the maximum amounts that Wisconsin Medicaid will reimburse providers for each procedure. The maximum allowable fee amount determines the copayment amount providers may request from a recipient. Refer to Appendix 1 of this handbook for current

procedure codes and copayment amounts for chiropractic services.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on copayment requirements.

### Copayment Exemptions

Except as noted below, recipients are responsible for paying part of the costs involved in obtaining chiropractic services.

Copayment exemptions include:

- Emergency services.
- Services covered by a Wisconsin Medicaid-contracted managed care program to enrollees of the managed care program, if the managed care program contracts to provide chiropractic services.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.

Wisconsin Medicaid will automatically deduct the appropriate copayment amount from the reimbursed amount for the covered chiropractic service.

All providers who provide a service that requires a recipient copayment are required to make a reasonable attempt to collect that copayment from the recipient. Providers are not allowed to waive the recipient copayment requirement at their discretion. The provider cannot deny services to a recipient who fails to make a copayment.

### Wisconsin Medicaid HMO Coverage

Wisconsin Medicaid HMOs are not required to cover medically necessary chiropractic services. If a Medicaid HMO elects not to cover chiropractic services, the services may be covered under Medicaid fee-for-service.

### *Medicaid HMOs That **Do Not** Cover Chiropractic Services*

If a Medicaid HMO elects not to cover chiropractic services, chiropractic providers treating these HMO enrollees as fee-for-service recipients are required to follow all Medicaid fee-for-service policies, billing procedures, and PA procedures. This includes collecting the appropriate copayment amount when applicable. Providers should bill Wisconsin Medicaid their usual and customary charges.

### *Medicaid HMOs That **Do** Cover Chiropractic Services*

If a Medicaid HMO covers chiropractic services, the enrollee is required to see an HMO network provider unless the HMO authorizes a non-network provider to provide the service. All non-network chiropractic providers are required to receive PA from the HMO to treat the Medicaid HMO enrollee. If the chiropractic service is covered by the HMO, the recipient is exempt from the copayment requirement.

### *Checking Eligibility, HMO Enrollment, and HMO Chiropractic Coverage*

Providers should always verify the eligibility of any recipient they are serving. The Wisconsin Medicaid EVS will indicate if the recipient is enrolled in an HMO and if the HMO covers chiropractic services. For more information on the EVS, refer to the Provider Resources section of the All-Provider Handbook.

## **Documentation Requirements**

All providers, including chiropractors, are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and medical and financial records, according to HFS 106.02(9)(a), Wis. Admin. Code. This includes documenting all new spells of illness (SOI) in the recipient's medical record. HFS 107.15(3)(b), Wis.

Admin. Code, defines an SOI as one of the following:

- An acute onset of a new spinal subluxation.
- An acute onset of an aggravation of pre-existing spinal subluxation by injury.
- An acute onset of a change in a pre-existing spinal subluxation based on objective findings.

The initial visit and 20 manipulations per provider per SOI do not require PA. Prior authorization is needed for more than 20 manipulations per SOI. Refer to the Prior Authorization chapter of this handbook for further PA information.

## **Reviews and Audits**

Wisconsin Medicaid periodically reviews provider records and other documentation. This includes the right to inspect, review, audit, and reproduce these records and documentation per HFS 106.02(9)(e)4, Wis. Admin. Code. Providers are required to permit authorized Medicaid staff access to any requested record or document, whether in written, electronic, photographic (e.g., X-ray), micrographic, or any other form.

## **Medical Documentation Guidelines**

To comply with medical documentation requirements outlined in HFS 106.02(9)(a), Wis. Admin. Code, providers are required to include documentation at the time of the initial and subsequent office visits.

### *Initial Office Visit*

Providers are required to include the following information in the documentation regarding the initial office visit at the time of the initial office visit, per HFS 106.02(9), Wis. Admin. Code:

- Date of service.
- Recipient's full name, date of birth, Medicaid identification number, and current address.
- Examining/treating provider's name.
- Name and address of the clinic or office where the service is provided.

**T**o comply with medical documentation requirements outlined in HFS 106.02(9)(a), Wis. Admin. Code, providers are required to include documentation at the time of the initial and subsequent office visits.

**W**isconsin Medicaid requires that providers document all office visits, including those subsequent to the initial visit.

- Accurate, complete, and legible description of the chief complaint, such as:
  - ✓ History and onset of the trauma or illness.
  - ✓ Previous episodes of complaint.
  - ✓ Palliative and provocative factors.
  - ✓ Quality, radiation, frequency, and severity of pain.
- Clinical findings, such as:
  - ✓ Palpation.
  - ✓ Provocative orthopedic and neurologic tests.
  - ✓ Range of motion.
  - ✓ Reflexes.
  - ✓ Vital signs.
- Diagnosis or medical/chiropractic impression.
- Plan of care (POC), which must include:
  - ✓ Estimated number of manipulations required to treat the subluxation over the anticipated period of time.
  - ✓ Home exercises and/or modification of daily activity, if applicable.
  - ✓ Short- and long-term goals.
  - ✓ Treatment and other therapies, if applicable.
- Studies ordered and report of findings, such as laboratory or X-ray studies. (Refer to the X-Rays section of this chapter.)
- Examining/treating chiropractor's signature and date signed.
- Relevant entries of change(s) compared to the previous DOS, such as:
  - ✓ Patient's chief complaint.
  - ✓ Objective findings.
  - ✓ Diagnostic impression/assessment.
  - ✓ Plan of care, including treatment schedule for the current DOS in relation to the initial DOS (e.g., "2<sup>nd</sup> treatment of 6 treatments anticipated" or "2 of 6 Tx").
- Changes to the POC.
- Examining/Treating provider's signature and date signed.

### *X-Rays*

Providers are required to include the following information in the documentation on all laboratory and X-ray study orders:

- Examining/Treating provider's full legal name.
- Name and address of the clinic or office where the service is provided.
- Recipient's full name, date of birth, Medicaid identification number, and current address.
- Date of laboratory or X-ray study.
- Reason for the study.
- Complete report of the findings.
- Provider's signature and date signed.

### *Spinal Supports*

The spinal support documentation must include the following:

### *Subsequent Visits*

Wisconsin Medicaid requires that providers document all office visits, including those subsequent to the initial visit. Providers are required to include the following information in the documentation at the time of the subsequent office visit(s):

- Examining/Treating provider's full legal name.
- Name and address of the clinic or office where the service is provided.
- Recipient's full name and address, if the address has changed.
- Date of service.
- Reason for prescribing the spinal support.
- Type of support including a description, the manufacturer, and brand name.
- Copy of the instructions given to the recipient.
- Recipient's dated signature indicating specifically which support was received.
- Follow-up documentation at two to three weeks or the next visit thereafter which includes recipient compliance and evaluation of equipment effectiveness.

**Signature Requirements**

Providers are required to sign and date all clinical entries made to a recipient's medical record at the time of the visit. This signature and date must accompany the documentation of every visit.

To obtain financial and other documentation requirements, refer to Wisconsin Administrative Code or to the Provider Rights and Responsibilities section of the All-Provider Handbook.

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# Covered Services

Only Medicaid-certified chiropractors may be reimbursed for providing medically necessary Medicaid-covered chiropractic services to Medicaid recipients. Refer to Appendix 3 of this handbook for a list of Medicaid-allowable diagnosis codes for chiropractic services.

## Manual Manipulations of the Spine

**W**isconsin Medicaid reimburses for manual manipulations of the spine only when the recipient's diagnosis is subluxation. Wisconsin Medicaid *does not* cover manipulations for strains and sprains.

Wisconsin Medicaid covers manual manipulations of the spine to treat a spinal subluxation as stated in HFS 107.15(2), Wis. Admin. Code. Wisconsin Medicaid reimburses for manual manipulations of the spine only when the recipient's diagnosis is subluxation. Wisconsin Medicaid *does not* cover manipulations for strains and sprains.

The initial visit and 20 manipulations per provider per spell of illness (SOI) do not require prior authorization (PA). Prior authorization is needed for more than 20 manipulations per SOI. Refer to the Prior Authorization chapter of this handbook for further PA information.

Wisconsin Medicaid covers one spinal adjustment per date of service per recipient.

## Diagnostic Urinalysis

A diagnostic urinalysis is covered only when performed on the same date as the initial office visit per HFS 107.15(4)(b), Wis. Admin. Code. The urinalysis must be related to the diagnosis of a spinal subluxation or when verifying a symptomatic condition beyond the scope of chiropractic practice.

## X-Rays

Wisconsin Medicaid covers an X-ray or set of X-rays to:

- Assist in diagnosing a spinal subluxation.
- Assess the existence of underlying conditions beyond the scope of chiropractic services.

An X-ray(s) is covered *only when performed on the same date as an initial office visit*, per HFS 107.15(4)(a), Wis. Admin. Code. Sectional views of multiple areas are covered if the diagnosis warrants multiple sectional views.

Providers are required to use the most appropriate *Current Procedural Terminology* procedure code that describes the X-ray service performed.

## Spinal Supports

Wisconsin Medicaid covers spinal supports for a subluxation of the spine. The spinal support must fit the recipient's body and be of sufficient strength to support the recipient's spine.

Spinal supports that are covered by Wisconsin Medicaid include, but are not limited to, the following:

- Cervical collars.
- Lumbo-sacral supports.
- Sacral supports.
- Spinal braces.
- Thoracic supports.

Wisconsin Medicaid requires PA for spinal supports in certain instances. Refer to the Prior Authorization chapter of this handbook for more information.

## Noncovered Services

Specific to chiropractic services, Wisconsin Medicaid does not cover:

- Any service submitted with a diagnosis code not included in Appendix 3 of this handbook.
- Consultations between providers regarding diagnosis or treatment per HFS 107.15(5), Wis. Admin. Code.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for a list of general noncovered services.

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# Prior Authorization

General information about prior authorization (PA) may be found in the All-Provider Handbook, including:

- Appeal procedures.
- Emergency situations. Emergency services are those which are necessary to prevent death or serious impairment of an individual's health.
- Prior authorization for out-of-state providers.
- Recipient loss of eligibility during treatment.
- Retroactive authorization.
- Supporting materials.

## Chiropractic Services Requiring Prior Authorization

Under HFS 107.15(3)(a), Wis. Admin. Code, Wisconsin Medicaid requires PA for:

- Services beyond the initial visit and 20 spinal manipulations per spell of illness. If more than 20 manipulations are necessary, the chiropractor should request PA at least four weeks in advance to ensure uninterrupted service.
- Purchase of spinal supports costing more than \$75.00.

**P**rior authorization does not guarantee reimbursement. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other requirements, must be met before the claim may be reimbursed.

Prior authorization does not guarantee reimbursement. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other requirements, must be met before the claim may be reimbursed.

## Obtaining Prior Authorization

### Prior Authorization Request Forms

Chiropractors should use the Prior Authorization Request Form (PA/RF) and

Prior Authorization/Chiropractic Attachment (PA/CA) to request PA. Refer to Appendices 7 through 11 of this handbook for samples of the PA/RF and the PA/CA, as well as the completion and submittal instructions.

### Obtaining Copies of Prior Authorization Forms

To obtain copies of the PA/RF and PA/CA, call Provider Services at (800) 947-9627 or (608) 221-9883 or write to:

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

Please specify the form being requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms.

Refer to Appendix 11 of this handbook for a reproducible copy of the PA/CA.

Providers may also download the PA/CA from the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/) in fillable Microsoft® Word and Portable Document Format (PDF) files.

### Submitting Prior Authorization Requests

Providers may submit PA requests by fax at (608) 221-8616 or by mailing them to:

Wisconsin Medicaid  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Refer to Appendix 12 of this handbook for more information on submitting PA requests by fax.

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# Claims Submission

## Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for most Wisconsin Medicaid-covered services. If the recipient is covered under Medicare or commercial health insurance, Wisconsin Medicaid reimburses that portion of the allowable cost remaining after exhausting all other insurance sources.

Refer to the Coordination of Benefits section of the All-Provider Handbook for information on Medicare and commercial insurance claims submission, exceptions, and the Other Coverage Discrepancy Report, HCF 1159.

## Medicare/Wisconsin Medicaid Dual Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are called dual entitlements. Claims for Medicare-covered services provided to dual entitlements must be submitted to Medicare *prior to* being submitted to Wisconsin Medicaid.

Usually, **Medicare-allowed** claims (called crossover claims) are automatically forwarded by the Medicare claims processor to Wisconsin Medicaid for processing. Wisconsin Medicaid reimburses the provider for coinsurance and deductible within certain limits described in the Coordination of Benefits section of the All-Provider Handbook. Wisconsin Medicaid reimburses providers for coinsurance and deductible on crossover claims even if the service provided was not a Medicaid-covered service.

If the service provided to a dual entitlement is covered by Medicare, but **Medicare denied** the claim, a provider should submit a new claim to Wisconsin Medicaid and indicate the appropriate Medicare disclaimer code on the claim. Refer to Appendix 4 of this handbook for a list of Medicare disclaimer codes.

Providers are strongly encouraged to always obtain prior authorization (PA) for dual-entitlement recipients for services requiring PA from Wisconsin Medicaid. This ensures proper processing by Wisconsin Medicaid if Medicare denies coverage.

## Claims Submission Deadline

Wisconsin Medicaid must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the Claims Submission section of the All-Provider Handbook for information on exceptions to the claims submission deadline and requirements for submission to Timely Filing Appeals (formerly known as Late Billing Appeals).

## Claims Submission Options

### Electronic Claims Submission

Wisconsin Medicaid provides Provider Electronic Solutions software for billing electronically. If interested in billing electronically, please call the Division of Health Care Financing Electronic Data Interchange (EDI) Helpdesk at (608) 221-9036, or e-mail [wiedi@dhfs.state.wi.us](mailto:wiedi@dhfs.state.wi.us) to request the appropriate information.

For EDI information regarding trading partners and data exchange methods (e.g., 835 Health Care Claim Payment/Advice and 837 electronic claims transactions), refer to the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/) or call the EDI Helpdesk at (608) 221-9036.

**W**isconsin Medicaid must receive all claims for services provided to eligible recipients within 365 days from the date of service.

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Medicaid-certified chiropractic providers submit electronic claims on the 837 Health Care Claim: Professional transaction (837P). Refer to the Medicaid Web site for the 837P companion document.

Wisconsin Medicaid processes claims that providers submit electronically. Electronic claims submission may reduce claim errors. All claims that providers submit, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

### Paper Claims Submission

Providers submitting paper claims are required to use the CMS 1500 claim form. Wisconsin Medicaid denies claims for services submitted on any other paper claim form than the CMS 1500 claim form. Refer to Appendices 4 through 6 of this handbook for the CMS 1500 completion instructions and sample claim forms.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Submit completed forms to:

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

## Claim Components

### Diagnosis Codes

Refer to Appendix 3 of this handbook for allowable chiropractic diagnosis codes.

### Procedure Codes

Medicaid-allowed procedure codes and their descriptions are listed in Appendix 1 of this handbook. Claims or adjustments received containing procedure codes other than those

listed in Appendix 1 of this handbook or published in subsequent *Updates* are denied.

### Billed Amounts

Providers are required to bill their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. Providers may not discriminate against Wisconsin Medicaid recipients by charging a higher fee for the service than is charged to a private-pay patient.

Wisconsin Medicaid automatically deducts applicable copayment amounts from Wisconsin Medicaid payments. Do not reduce the billed amount of a claim by the amount of recipient copayment.

## Claims Submission Specifications

### New Spell of Illness

To indicate a new spell of illness (SOI), enter the date of the new SOI and procedure code 99201 on the CMS 1500 claim form or 837P electronic transaction. On the first claim for the new SOI, enter the appropriate charges for procedure code 99201.

For subsequent claims for services related to the new SOI, indicate the date of the SOI and procedure code 99201 on the CMS 1500 or 837P. Do not enter any charges on a claim if reimbursement was received for the office visit.

Providers are required to maintain documentation regarding a recipient's SOI in the recipient's medical record. Refer to the General Information chapter of this handbook for documentation that must be included in the recipient's medical record.

**W**isconsin Medicaid automatically deducts applicable copayment amounts from Wisconsin Medicaid payments.

## X-Rays

Submit claims using the single, most appropriate procedure code that describes the service. Providers must not submit claims with multiple radiology codes to describe a single service that was provided. Refer to Appendix 1 of this handbook for allowable X-ray procedure codes.

## Follow-Up to Claims Submission

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status (R/S) Report and the 835 Health Care Claim Payment/Advice transaction either as paid or denied.

Wisconsin Medicaid takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Reconsideration Request form, HCF 13046, to Wisconsin Medicaid.

Refer to the Claims Submission section of the All-Provider Handbook for information about:

- Adjustments to paid claims.
- Denied claims.
- Duplicate payments.
- Good Faith claims and filing procedures.
- The R/S Report.
- Return of overpayments.

**P**roviders are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status (R/S) Report and the 835 Health Care Claim Payment/Advice transaction either as paid or denied.

## Reimbursement

### Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. (Wisconsin Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee for the procedure.) Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted to Wisconsin Medicaid, the Wisconsin State Legislature's budgetary constraints, and other relevant economic limitations.

Providers are encouraged to obtain a schedule of Wisconsin Medicaid maximum allowable fees for chiropractic services from one of the following sources:

- An electronic version on Wisconsin Medicaid's Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).
- Purchase a paper copy by writing to:

Wisconsin Medicaid  
Provider Maintenance  
6406 Bridge Rd  
Madison WI 53784-0006

Call Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.

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# **Appendix**

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## Appendix 1

### Procedure Code and Copayment Table for Chiropractic Services

The following table lists the *current* Medicaid-allowed procedure codes, descriptions, and copayment amounts for covered chiropractic services. Consult the Chiropractic Services Maximum Allowable Fee Schedule for maximum allowable fees. The following charts are periodically revised in *Wisconsin Medicaid and BadgerCare Updates*.

Procedure Code	Description	Copayment
L0120	Cervical, flexible, nonadjustable (foam collar)	\$1.00
L0140	Cervical, semi-rigid, adjustable (plastic collar)	\$2.00
L0210	Thoracic, rib belt	\$1.00
L0500	Lumbar-sacral-orthosis (LSO), flexible, (lumbo-sacral support)	\$3.00
L0600	Sacroiliac, flexible (sacroiliac surgical support)	\$3.00
72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral	\$3.00
72020	Radiologic examination, spine, single view, specify level	\$3.00
72040	Radiologic examination, spine, cervical; two or three views	\$3.00
72050	minimum of four views	\$3.00
72052	complete, including oblique and flexion and/or extension studies	\$3.00
72070	Radiologic examination, spine; thoracic, two views	\$3.00
72100	Radiologic examination, spine, lumbosacral; two or three views	\$3.00
72110	minimum of four views	\$3.00
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	\$3.00
72200	Radiologic examination, sacroiliac joints; less than three views	\$1.00
72202	three or more views	\$3.00
72220	Radiologic examination, sacrum and coccyx, minimum of two views	\$3.00
73000	Radiologic examination; clavicle, complete	\$1.00
73010	scapula, complete	\$3.00
73020	Radiologic examination, shoulder; one view	\$1.00
73030	complete, minimum of two views	\$3.00
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	\$3.00
73060	humerus, minimum of two views	\$1.00
73070	Radiologic examination, elbow; two views	\$1.00
73080	complete, minimum of three views	\$1.00
73500	Radiologic examination, hip, unilateral; one view	\$1.00
73510	complete, minimum of two views	\$3.00

Procedure Code	Description	Copayment
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	\$3.00
73540	Radiologic examination, pelvis and hips, infant or child, minimum of two views	\$0.00
73550	Radiologic examination, femur, two views	\$3.00
73560	Radiologic examination, knee; one or two views	\$1.00
73562	three views	\$1.00
73564	complete, four or more views	\$1.00
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	\$0.50
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	\$1.00
98941	spinal, three to four regions	\$1.00
98942	spinal, five regions	\$1.00
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> <li>• A problem focused history;</li> <li>• A problem focused examination; and</li> <li>• Straightforward medical decision making.</li> </ul>	\$1.00

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for current policy

## Appendix 2

### Place of Service Codes for Chiropractic Services

The following table lists the Medicaid-allowable place of service (POS) codes providers are required to use for chiropractic services.

POS Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
20	Urgent Care Facility
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

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## Appendix 3

### Wisconsin Medicaid-Allowable Diagnosis Codes for Chiropractic Services

The following tables list the Medicaid-allowable diagnosis codes for chiropractic services from the *International Classification of Diseases, Ninth Revision, Clinical Modification*.

<b>Invertebral Disc Disorders</b>	
722.0	Displacement of cervical intervertebral disc without myelopathy Neuritis (brachial) or radiculitis due to displacement or rupture of cervical intervertebral disc Any condition classifiable to 722.2 of the cervical or cervicothoracic intervertebral disc
722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.10	Lumbar intervertebral disc without myelopathy Lumbago or sciatica due to displacement of intervertebral disc Neuritis or radiculitis due to displacement or rupture of lumbar intervertebral disc Any condition classifiable to 722.2 of the lumbar or lumbosacral intervertebral disc
722.11	Thoracic intervertebral disc without myelopathy Any condition classifiable to 722.2 of thoracic intervertebral disc

<b>Other, Multiple, and Ill-Defined Dislocations</b>	
839.0	Cervical vertebra, closed Cervical spine, neck
839.00	Cervical vertebra, unspecified
839.01	First cervical vertebra
839.02	Second cervical vertebra
839.03	Third cervical vertebra
839.04	Fourth cervical vertebra
839.05	Fifth cervical vertebra
839.06	Sixth cervical vertebra
839.07	Seventh cervical vertebra
839.08	Multiple cervical vertebrae
839.2	Thoracic and lumbar vertebra, closed
839.20	Lumbar vertebra
839.21	Thoracic vertebra Dorsal (thoracic) vertebra
839.4	Other vertebra, closed
839.41	Coccyx
839.42	Sacrum Sacroiliac (joint)
839.49	Other

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## Appendix 4

### CMS 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

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 [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/) for more information about the EVS.

#### **Element 1 — Program Block/Claim Sort Indicator**

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

#### **Element 1a — Insured's I.D. Number**

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.

#### **Element 2 — Patient's 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.

#### **Element 3 — Patient's Birth Date, Patient's Sex**

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

#### **Element 4 — Insured's Name (not required)**

#### **Element 5 — Patient's Address**

Enter the complete address of the recipient's place of residence, if known.

#### **Element 6 — Patient Relationship to Insured (not required)**

#### **Element 7 — Insured's Address (not required)**

#### **Element 8 — Patient Status (not required)**

#### **Element 9 — Other Insured's Name**

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

## Appendix 4 (Continued)

If the EVS indicates that the recipient has dental (“DEN”) insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
<b>OI-P</b>	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
<b>OI-D</b>	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.
<b>OI-Y</b>	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> <li>✓ The recipient denied coverage or will not cooperate.</li> <li>✓ The provider knows the service in question is not covered by the carrier.</li> <li>✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims.</li> <li>✓ Benefits are not assignable or cannot get assignment.</li> <li>✓ Benefits are exhausted.</li> </ul>

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

### Element 10 — Is Patient’s Condition Related to (not required)

### Element 11 — Insured’s Policy, Group, or FECA Number

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank 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 that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

## Appendix 4 (Continued)

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

Code	Description
<b>M-5</b>	<p><b>Provider is not Medicare certified.</b> This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 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"> <li>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided.</li> <li>✓ The recipient is eligible for Medicare Part A.</li> <li>✓ The procedure provided is covered by Medicare Part A.</li> </ul> <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided.</li> <li>✓ The recipient is eligible for Medicare Part B.</li> <li>✓ The procedure provided is covered by Medicare Part B.</li> </ul>
<b>M-7</b>	<p><b>Medicare disallowed or denied payment.</b> 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"> <li>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.</li> <li>✓ The recipient is eligible for Medicare Part A.</li> <li>✓ 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.</li> </ul> <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.</li> <li>✓ The recipient is eligible for Medicare Part B.</li> <li>✓ 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.</li> </ul>
<b>M-8</b>	<p><b>Noncovered Medicare service.</b> 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"> <li>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.</li> <li>✓ The recipient is eligible for Medicare Part A.</li> <li>✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis).</li> </ul> <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.</li> <li>✓ The recipient is eligible for Medicare Part B.</li> <li>✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).</li> </ul>

**Elements 12 and 13 — Authorized Person's Signature (not required)**

**Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)**

**Element 15 — If Patient Has Had Same or Similar Illness (not required)**

## Appendix 4 (Continued)

### Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

### Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

### Element 18 — Hospitalization Dates Related to Current Services (not required)

### Element 19 — Reserved for Local Use (not required)

### Element 20 — Outside Lab? (not required)

### Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology (“E”) and manifestation (“M”) codes may not be used as a primary diagnosis. The diagnosis description is not required.

Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. Refer to Appendix 3 of this handbook for a list of allowable diagnosis codes for chiropractic services.

### Element 22 — Medicaid Resubmission (not required)

### Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

### Element 24A — Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the “From” field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the “From” field and enter subsequent DOS in the “To” field by listing **only** the date(s) of the month. For example, for DOS on December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the “From” field and indicate 08/15/22 in the “To” field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

### Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service.

### Element 24C — Type of Service (not required)

### Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.



## Appendix 4 (Continued)

### Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

### Element 24F — \$ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

### Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

### Element 24H — EPSDT/Family Plan (not required)

### Element 24I — EMG (not required)

### Element 24J — COB (not required)

### Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

### Element 25 — Federal Tax I.D. Number (not required)

### Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

### Element 27 — Accept Assignment (not required)

### Element 28 — Total Charge

Enter the total charges for this claim.

### Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

### Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

### Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

*Note:* The signature may be a computer-printed or typed name and date or a signature stamp with the date.

### Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

### Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone #

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, address, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

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# Appendix 5

## Sample CMS 1500 Claim Form

### (New Spell of Illness)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																	
<b>1. MEDICARE</b> <input type="checkbox"/> <b>MEDICAID</b> <input checked="" type="checkbox"/> <b>CHAMPUS</b> <input type="checkbox"/> <b>CHAMPVA</b> <input type="checkbox"/> <b>GROUP HEALTH PLAN</b> <input type="checkbox"/> <b>FECA BLK LUNG</b> <input type="checkbox"/> <b>OTHER</b> <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					<b>1a. INSURED'S I.D. NUMBER</b> (FOR PROGRAM IN ITEM 1) <b>1234567890</b>																																																																																																																																																																																												
<b>2. PATIENT'S NAME</b> (Last Name, First Name, Middle Initial) <b>Recipient, Im A.</b>					<b>3. PATIENT'S BIRTH DATE</b> <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																																																																																																																																																																												
<b>5. PATIENT'S ADDRESS</b> (No., Street) <b>609 Willow St</b>					<b>6. PATIENT RELATIONSHIP TO INSURED</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																																																												
<b>CITY</b> <b>Anytown</b>			<b>STATE</b> <b>WI</b>		<b>7. INSURED'S ADDRESS</b> (No., Street)			<b>8. PATIENT STATUS</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																																																																																																																																																																																									
<b>ZIP CODE</b> <b>55555</b>			<b>TELEPHONE</b> (Include Area Code) <b>(XXX) XXX-XXXX</b>		<b>9. OTHER INSURED'S NAME</b> (Last Name, First Name, Middle Initial) <b>OI-P</b>			<b>10. IS PATIENT'S CONDITION RELATED TO:</b> a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																									
<b>9. OTHER INSURED'S NAME</b> (Last Name, First Name, Middle Initial) <b>OI-P</b>					<b>11. INSURED'S POLICY GROUP OR FECA NUMBER</b>																																																																																																																																																																																												
<b>a. OTHER INSURED'S POLICY OR GROUP NUMBER</b>					<b>a. INSURED'S DATE OF BIRTH</b> <b>MM DD YY</b> M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																												
<b>b. OTHER INSURED'S DATE OF BIRTH</b> <b>MM DD YY</b> M <input type="checkbox"/> F <input type="checkbox"/>					<b>b. EMPLOYER'S NAME OR SCHOOL NAME</b>																																																																																																																																																																																												
<b>c. EMPLOYER'S NAME OR SCHOOL NAME</b>					<b>c. INSURANCE PLAN NAME OR PROGRAM NAME</b>																																																																																																																																																																																												
<b>d. INSURANCE PLAN NAME OR PROGRAM NAME</b>					<b>10d. RESERVED FOR LOCAL USE</b>																																																																																																																																																																																												
<b>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																																																																	
<b>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																																	
<b>14. DATE OF CURRENT:</b> <b>MM DD YY</b> <b>ILLNESS</b> (First symptom) OR <b>INJURY</b> (Accident) OR <b>PREGNANCY</b> (LMP)					<b>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.</b> GIVE FIRST DATE <b>MM DD YY</b>																																																																																																																																																																																												
<b>17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</b>					<b>17a. I.D. NUMBER OF REFERRING PHYSICIAN</b>																																																																																																																																																																																												
<b>19. RESERVED FOR LOCAL USE</b>																																																																																																																																																																																																	
<b>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.</b> (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>839.20</b> 3. _____ 2. _____ 4. _____																																																																																																																																																																																																	
<table border="1"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPST/ Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>12</td><td>09</td><td>03</td><td></td><td></td><td>11</td><td></td><td></td><td>99201</td><td></td><td>1</td><td></td><td>XX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>12345678</td> </tr> <tr> <td>12</td><td>09</td><td>03</td><td></td><td></td><td>11</td><td></td><td></td><td>72020</td><td></td><td>1</td><td></td><td>XX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>12345678</td> </tr> <tr> <td>12</td><td>09</td><td>03</td><td></td><td></td><td>11</td><td></td><td></td><td>98940</td><td></td><td>1</td><td></td><td>XX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>12345678</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPST/ Family Plan		EMG		COB		RESERVED FOR LOCAL USE		12	09	03			11			99201		1		XX	XX	1.0								12345678	12	09	03			11			72020		1		XX	XX	1.0								12345678	12	09	03			11			98940		1		XX	XX	1.0								12345678																																																																					
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<b>25. FEDERAL TAX I.D. NUMBER</b> <input type="checkbox"/> <b>SSN</b> <input type="checkbox"/> <b>EIN</b> <input type="checkbox"/>					<b>26. PATIENT'S ACCOUNT NO.</b>					<b>27. ACCEPT ASSIGNMENT?</b> (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																							
<b>28. TOTAL CHARGE</b> <b>\$ XXX XX</b>					<b>29. AMOUNT PAID</b> <b>\$ XXX XX</b>					<b>30. BALANCE DUE</b> <b>\$ XX XX</b>																																																																																																																																																																																							
<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</b> INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>J.M. Williams</b> <b>MM/DD/YY</b> SIGNED _____ DATE _____										<b>32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED</b> (If other than home or office) <b>I.M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b> <b>87654321</b> PIN# _____ GRP# _____																																																																																																																																																																																							

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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**CARRIER** →

## PATIENT AND INSURED INFORMATION

# Appendix

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,  
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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## Appendix 7

### Prior Authorization Request Form (PA/RF) Completion Instructions for Chiropractic Services

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Chiropractic Attachment (PA/CA), by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to:

Wisconsin Medicaid  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

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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 — 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 “118” (chiropractic). The processing type is a three-digit code used to identify a category of service requested.

##### 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.

## Appendix 7 (Continued)

### 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. Refer to Appendix 3 of this handbook for a diagnosis code that is most relevant to the 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. Refer to Appendix 3 of this handbook for a list of Medicaid-allowable diagnosis codes for chiropractic services.

#### Element 14 — Requested Start Date

Enter the requested start date for the service(s) in MM/DD/YY format, if a specific start date is requested.

#### Element 15 — Performing Provider Number

Enter the eight-digit Medicaid provider number of the provider who will be providing the service only if this number is different from the billing provider number listed in Element 4.

#### Element 16 — Procedure Code

Enter the appropriate procedure code for each service/procedure/item requested.

#### Element 17 — Modifiers (not required)

#### Element 18 — POS

Enter the place of service (POS) code designating where the requested service/procedure/item would be provided/performed. Refer to Appendix 2 of this handbook for a list of Medicaid-allowable POS codes for chiropractic services.

#### Element 19 — Description of Service

Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.



## Appendix 7 (Continued)

### Element 20 — QR

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

### Element 21 — Charge

Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item 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.

### Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing this service/procedure/item 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.*

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# Appendix 8

## Sample Prior Authorization Request Form (PA/RF)

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
Division of Health Care Financing  
HCF 11018 (Rev. 10/03)

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

### WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

<b>FOR MEDICAID USE — ICN</b>						AT	Prior Authorization Number
<b>SECTION I — PROVIDER INFORMATION</b>							
1. Name and Address — Billing Provider (Street, City, State, Zip Code) <b>I.M. Provider 1 W. Williams Anytown, WI 55555</b>					2. Telephone Number — Billing Provider <b>(XXX) XXX-XXXX</b>		3. Processing Type <b>118</b>
					4. Billing Provider's Medicaid Provider Number <b>87654321</b>		
<b>SECTION II — RECIPIENT INFORMATION</b>							
5. Recipient Medicaid ID Number <b>1234567890</b>		6. Date of Birth — Recipient (MM/DD/YY) <b>MM/DD/YY</b>		7. Address — Recipient (Street, City, State, Zip Code) <b>1234 Street St. Anytown, WI 55555</b>			
8. Name — Recipient (Last, First, Middle Initial) <b>Recipient, Ima</b>		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F					
<b>SECTION III — DIAGNOSIS / TREATMENT INFORMATION</b>							
10. Diagnosis — Primary Code and Description <b>839.03 Third cervical vertebra</b>					11. Start Date — SOI		12. First Date of Treatment — SOI
13. Diagnosis — Secondary Code and Description					14. Requested Start Date <b>MM/DD/YY</b>		
15. Performing Provider Number <b>12345678</b>	16. Procedure Code <b>98940</b>	17. Modifiers 1 2 3 4	18. POS <b>11</b>	19. Description of Service <b>Chiropractic manipulations/adjustments</b>		20. QR <b>4.0</b>	21. Charge <b>XXX.XX</b>
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.						22. Total Charges	XXX.XX
23. SIGNATURE — Requesting Provider <i>I.M. Provider</i>						24. Date Signed MM/DD/YY	
<b>FOR MEDICAID USE</b>				Procedure(s) Authorized:		Quantity Authorized:	
<input type="checkbox"/> Approved <div style="display: flex; justify-content: space-around; width: 100%;"> <div style="border-bottom: 1px solid black; width: 150px;"></div>Grant Date <div style="border-bottom: 1px solid black; width: 150px;"></div>Expiration Date </div>							
<input type="checkbox"/> Modified — Reason:							
<input type="checkbox"/> Denied — Reason:							
<input type="checkbox"/> Returned — Reason:							
SIGNATURE — Consultant / Analyst						Date Signed	

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**Appendix 9**  
**Prior Authorization/Chiropractic Attachment (PA/CA) Completion**  
**Instructions (for photocopying)**

(A copy of the Prior Authorization/Chiropractic Attachment [PA/CA] Completion Instructions is located on the following pages.)

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for current policy

(This page was intentionally left blank.)

ARCHIVAL USE ONLY  
Refer to the Online Handbook  
for current policy

**WISCONSIN MEDICAID**  
**PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA) COMPLETION INSTRUCTIONS**

Wisconsin Medicaid requires certain 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 judgment about the case.

Attach the completed Prior Authorization/Chiropractic Attachment (PA/CA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) 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). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

**SECTION I — PROVIDER INFORMATION**

**Element 1 — Name — Provider**

Enter the name of the provider who would perform/provide the requested service/procedure.

**Element 2 — Address — Clinic or Office Where Service(s) is Provided**

Enter the address of the clinic or office where chiropractic services are actually performed.

**Element 3 — Wisconsin Medicaid Provider Number**

Enter the eight-digit Medicaid provider number of the chiropractor performing the service.

**Element 4 — Telephone Number — Provider**

Enter the telephone number, including area code, of the provider performing the service.

**SECTION II — RECIPIENT INFORMATION**

**Element 5 — Name — Recipient**

Enter the recipient's last name, 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 6 — Date of Birth**

Enter the recipient's date of birth in MM/DD/YYYY format.

**Element 7 — Wisconsin Medicaid Identification Number**

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

### SECTION III — SERVICE INFORMATION

**Element 8 — Total Number of Services Requested (Specify)**

Enter the total number of visits/services requested.

**Element 9 — Total Number of Weeks Requested**

Enter the total number of weeks to complete requested visits.

**Element 10 — Requested Start Date of Prior Authorization**

Enter the date to begin services in MM/DD/YYYY format.

### SECTION IV — SUPPORTING INFORMATION

**Element 11 — Date of Spell of Illness**

Enter the date the spell of illness (SOI) began in MM/DD/YYYY format.

**Element 12 — Date of Beginning Treatment**

Enter the first date of treatment for this SOI in MM/DD/YYYY format.

**Element 13 — History**

- a. Initial — Explain history of initial treatment for recipient. (Leave blank if this SOI is initial treatment.)
- b. Spell of Illness — Explain history for this SOI.
- c. Previous and/or Concurrent Care — List previous or concurrent care relating to this SOI, if known.

**Element 14 — Subjective Complaints**

- a. Initial — Explain initial complaints. (Leave blank if this SOI is initial treatment.)
- b. Spell of Illness — Explain complaints relating to this SOI.

**Element 15 — Objective Findings**

- a. Initial — Explain objective findings of initial treatment. (Leave blank if this SOI is initial treatment.)
- b. Spell of Illness — Explain objective findings relating to this SOI.
- c. Diagnosis — Enter the appropriate Medicaid-allowable diagnosis code.

**Element 16 — Subjective Progress**

Enter the subjective progress of the recipient. Are the frequency, intensity, distribution, and duration less? What has improved subjectively?

**Element 17 — Objective Progress**

Enter the objective progress of the recipient. What former positive tests are now negative or less positive?

**Element 18 — Prognosis / Treatment Plan**

Enter the prognosis and treatment plan for the recipient.

**Element 19 — Additional Comments**

Enter any additional comments that may assist the Medicaid medical consultants' decision in adjudicating the PA request. Examples include lifestyle choices, general health, or extenuating circumstances which slow the recipient's progress.

**Elements 20 and 21 — SIGNATURE — Examining / Treating Provider and Date Signed**

The examining or treating provider must sign this element. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

*Note:* The signature may be a computer-printed or typed name and date or a signature stamp with the date.



# Appendix 10

## Sample Prior Authorization/Chiropractic Attachment (PA/CA)

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
Division of Health Care Financing  
HCF 11029 (Rev. 02/04)

STATE OF WISCONSIN  
HFS 107.15(3), Wis. Admin. Code

### WISCONSIN MEDICAID PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA)

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 the Prior Authorization/Chiropractic Attachment (PA/CA) Completion Instructions (HCF 11029A).

#### SECTION I — PROVIDER INFORMATION

1. Name — Provider

**I.M. Provider**

2. Address — Clinic or Office Where Service(s) is Provided

**1 W Williams**

**Anytown WI 55555**

3. Wisconsin Medicaid Provider Number

**87654321**

4. Telephone Number — Provider

**(XXX) XXX-XXXX**

#### SECTION II — RECIPIENT INFORMATION

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

**Recipient, Ima**

6. Date of Birth (MM/DD/YYYY)

**XX/XX/XXXX**

7. Wisconsin Medicaid Identification Number

**1234567890**

#### SECTION III — SERVICE INFORMATION

8. Total Number of Services Requested (Specify)

**Three adjustments**

9. Total Number of Weeks Requested

**Six weeks**

10. Requested Start Date of Prior Authorization (MM/DD/YYYY)

**XX/XX/XXXX**

#### SECTION IV — SUPPORTING INFORMATION

11. Date of Spell of Illness (MM/DD/YYYY)

**XX/XX/XXXX**

12. Date of Beginning Treatment (MM/DD/YYYY)

**XX/XX/XXXX**

13. History

a) Initial

**Recipient is a 50-year old female, 5'2" in height, weighing approximately 150 pounds. She is a nonsmoker, eats a balanced diet, and exercises regularly. She initially presented to our office on 01/02/2000 seeking help for headaches. With an onset in May 1998 following an MVA when she was rear-ended by a semi while driving a Chevy Cavalier which was stopped at a traffic light. Her headaches resolved after two months of treatments and she was discharged.**

b) Spell of Illness

**Recipient presented 11/03/2003 complaining of low back and right leg pain. She stated that the pain began within hours of falling on the ice in her driveway on 11/01/2003.**

c) Previous and / or Concurrent Care

**Recipient stated she alternated between a heating pad and ice packs on her back and leg along with an increase in bed rest. This produced no results.**

Continued

SECTION IV — SUPPORTING INFORMATION (Continued)

14. Subjective Complaints

a) Initial

Recipient described the headaches as throbbing pain rated 8 on a scale from 1 to 10 with 10 being debilitating. The pain encompassed the entire head, particularly behind the eyes. The headaches occurred about twice a week and lasted for a day. Pain was aggravated by bright light, noise, and motion, and she found it difficult to fulfill normal duties during episodes of headaches.

b) Spell of Illness

Recipient experiencing low back pain with the right side hurting more than the left. Pain is also felt down the back of the right leg to the knee. Pain is rated a 6 on a scale of 1 to 10. The pain is fairly constant and is relieved by lying flat on her back. Pain is aggravated by standing, bending, or lifting. Sleep is frequently interrupted by pain, particularly when she turns in bed.

15. Objective Findings

a) Initial

BP 132/85 left, 133/86 right, pulse 84, cervical flexion 30°/45°, extension 25°/45°, left flexion 20°/45°, right flexion 20°/45° with pain (R) C5-C6, (L) rotation 60°/80°, (R) 30°/80° with pain (R) C5-C6 paraspinal.

(+) foraminal compression on (R) with pain in (R) C5 dermatome.

(+) (R) maximum cervical compression with pain (R) C5-C6. T/T fibers (R) C5-C6.

b) Spell of Illness

SLR (+) 30° (R), thoracolumbar flexion 90°, extension 35°, (R) flexion 15° with pain (R) lumbar, (L) flexion 35°, T/T fibers L5-S<sub>1</sub>; walks with a noticeable limp; MRI indicates (R) postero-lateral disk herniation. X-rays revealed mild to moderate DJD at L4-L5, L5-S<sub>1</sub>.

c) Diagnosis 839.20

16. Subjective Progress

Recipient reports pain localized to (R) low back rated 2/10 when bending and lifting. Sleep is not interrupted by pain.

17. Objective Progress

(R)SLR (+) 70°, lumbar flexion 80°/90°, extension 20°/30° with pain at L5-S<sub>1</sub> level. Gait is even without a limp.

18. Prognosis / Treatment Plan

Recipient's progress was slowed due to the disk herniation. She has resumed her normal activities.

Recipient will be treated once in next 2 weeks with gradual increase in exercise and walking program, followed with one treatment in next 3 weeks with another increase in exercise routine. Finally, there will be one treatment in next 4 weeks and anticipate discharge.

19. Additional Comments

Recipient required additional time and treatments to stabilize the lumbar spine due to the disk herniation.

20. SIGNATURE — Examining / Treating Provider	21. Date Signed (MM/DD/YYYY)
<i>J.M. Provider</i>	XX/XX/XXXX

**Appendix 11**  
**Prior Authorization/Chiropractic Attachment (PA/CA)**  
**(for photocopying)**

(A copy of the Prior Authorization/Chiropractic Attachment [PA/CA] is located on the following pages.)

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**WISCONSIN MEDICAID**  
**PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA)**

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 the Prior Authorization/Chiropractic Attachment (PA/CA) Completion Instructions (HCF 11029A).

**SECTION I — PROVIDER INFORMATION**

1. Name — Provider

2. Address — Clinic or Office Where Service(s) is Provided

3. Wisconsin Medicaid Provider Number

4. Telephone Number — Provider

**SECTION II — RECIPIENT INFORMATION**

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

6. Date of Birth (MM/DD/YYYY)

7. Wisconsin Medicaid Identification Number

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**SECTION III — SERVICE INFORMATION**

8. Total Number of Services Requested (Specify)

9. Total Number of Weeks Requested

10. Requested Start Date of Prior Authorization (MM/DD/YYYY)

**SECTION IV — SUPPORTING INFORMATION**

11. Date of Spell of Illness (MM/DD/YYYY)

12. Date of Beginning Treatment (MM/DD/YYYY)

13. History  
a) Initial

b) Spell of Illness

c) Previous and / or Concurrent Care

*Continued*

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**SECTION IV — SUPPORTING INFORMATION (Continued)**

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14. Subjective Complaints

a) Initial

b) Spell of Illness

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15. Objective Findings

a) Initial

b) Spell of Illness

c) Diagnosis

---

16. Subjective Progress

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17. Objective Progress

---

18. Prognosis / Treatment Plan

---

19. Additional Comments

---

20. **SIGNATURE** — Examining / Treating Provider

21. Date Signed (MM/DD/YYYY)

---

## Appendix 12

### Prior Authorization Fax Procedures

Providers may fax prior authorization (PA) requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any Wisconsin Medicaid fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to Wisconsin Medicaid, providers should be aware of the following:

#### Include a Fax Transmittal Cover Letter

Include a completed fax transmittal cover letter that includes the following:

- Date of the fax transmission.
- Number of pages including the cover sheet. The Medicaid fax clerk will contact the provider by fax or telephone if all the pages do not transmit. (Refer to the following section for instructions if all the pages do not transmit.)
- Provider contact person and telephone number. The Wisconsin Medicaid fax clerk may contact the provider with any questions about the fax transmission.
- Wisconsin Medicaid provider identification number.
- Fax number to which Wisconsin Medicaid may send its adjudication decision.
- To: "Wisconsin Medicaid Prior Authorization."
- Wisconsin Medicaid's fax number ([608] 221-8616). Prior authorization requests sent to any other Wisconsin Medicaid fax number may result in processing delays.
- Wisconsin Medicaid's telephone numbers. For specific PA questions, providers should call (800) 947-9627 or (608) 221-9883. For faxing questions, providers should call (608) 221-4746, **extension 3064\***.

#### Incomplete Fax Transmissions

If all the pages listed on the initial cover sheet do not transmit (i.e., pages have stuck together, the fax machine has jammed, or some other error has stopped the fax transmission) or if the PA request is missing information, providers will receive the following by fax from the Medicaid fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that Medicaid received.

If a PA request is returned to the provider due to faxing problems, providers should:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the *entire* original fax transmission *and* the additional information requested by the fax clerk to (608) 221-8616.

#### General Guidelines

When faxing information to Wisconsin Medicaid, providers should not reduce the size of the Prior Authorization Request Form (PA/RF) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, Wisconsin Medicaid will mail the decision back to the provider.

**\*Extension 3064 is no longer valid. Please use extension 80118, effective immediately.**

Wisconsin Medicaid will attempt to fax the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call Medicaid's fax clerk at (608) 221-4746, **extension 3064\***, to check the status of the fax.

**\*Extension 3064 is no longer valid. Please use extension 80118, effective immediately.**

### **Prior Authorization Request Deadlines**

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has *not* changed. All actions regarding PA requests are made within the time frames outlined in the Prior Authorization section of the All-Provider Handbook.

Faxed PA requests must be received by 1:00 p.m., otherwise they will be considered received as of the following business day. Faxed PA requests received on Saturday or Sunday will be processed on the next business day.

### **Avoid Duplicating Prior Authorization Requests**

After faxing a PA request, providers should not send the original paperwork, such as the carbon PA/RF, by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will create duplicate PA requests and may result in delays.

### **Submitting New Prior Authorization Requests**

Providers should not photocopy and reuse the same PA/RF for other requests. When submitting a *new* request for PA, it must be submitted on a new PA/RF so that the request is processed under a new PA number. This requirement applies whether the PA request is submitted by fax or by mail.

### **Resubmitting Prior Authorization Requests**

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments, which includes Wisconsin Medicaid's 15-digit internal control number located on the top half of the PA/RF. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

### **For More Information**

Refer to the Prior Authorization section of the All-Provider Handbook for information on responses to PA requests and how to amend them.



# Glossary of Common Terms

## **Adjustment**

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

## **Allowed Claim**

A Medicaid or Medicare claim that has at least one service that is reimbursable.

## **BadgerCare**

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185 percent of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or “crowding out” private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients’ health care is administered through the same delivery system.

## **CMS**

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), the CMS administers Medicare, Medicaid, related quality assurance programs, and other programs.

## **CPT**

*Current Procedural Terminology.* A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

## **Crossover Claim**

A Medicare-allowed claim for a dual entitlee submitted to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

## **DHCF**

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state’s Medicaid plan. The state’s Medicaid plan is a comprehensive description of the state’s Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

## **DHFS**

Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

## **DHHS**

Department of Health and Human Services. The United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

## **DOS**

Date of service. The calendar date on which a specific medical service is performed.

## **Dual Entitlee**

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

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**EDI**

Electronic Data Interchange. The DHCF EDI department processes electronic transactions for Wisconsin Medicaid. For more information regarding the EDI Department, contact the EDI Helpdesk at (608) 221-9036 or e-mail [wiedi@dhfs.state.wi.us](mailto:wiedi@dhfs.state.wi.us).

**Emergency Services**

Those services which are necessary to prevent death or serious impairment of the health of the individual.

**EOB**

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid provider of the status or action taken on a claim.

**EVS**

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

**Fee-for-Service**

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

**Fiscal Agent**

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services (DHFS) to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

**HCPCS**

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes and national alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) to supplement CPT codes.

**HealthCheck**

A program which provides Medicaid-eligible children under age 21 with regular health screenings.

**ICD-9-CM**

*International Classification of Diseases, Ninth Revision, Clinical Modification*. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

**Maximum Allowable Fee Schedule**

A listing of all procedure codes allowed by Wisconsin Medicaid for a given provider type and the maximum allowable fee and relative value units (RVUs) Wisconsin Medicaid assigns to each procedure code. Providers may download service-specific fee schedules on the Medicaid Web site at [dhfs.wisconsin.gov/medicaid/](http://dhfs.wisconsin.gov/medicaid/).

**Medicaid**

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

## Medically Necessary

According to HFS 101.03(96m), Wis. Admin. Code, a service that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
  1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
  2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
  3. Is appropriate with regard to generally accepted standards of medical practice;
  4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
  5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
  6. Is not duplicative with respect to other services being provided to the recipient;
  7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
  8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
  9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

## Payee

Party to whom checks are made payable. The payee's address is used as the mailing address for checks and Remittance and Status (R/S) Reports.

## POS

Place of service. A two-digit code which identifies the place where the service was performed.

## QMB-Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. These recipients are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

## Qualifying Circumstances

Conditions that complicate the rendering of anesthesia services, including the extraordinary condition of the patient, special operative conditions, and unusual risk factors.

## R/S Report

Remittance and Status Report. A statement generated by Wisconsin Medicaid to inform the provider regarding the processing of the provider's claims.

## Spell of Illness

Per HFS 107.15, Wis. Admin. Code, a spell of illness is defined as one of the following:

- An acute onset of a new spinal subluxation.
- An acute onset of an aggravation of pre-existing spinal subluxation by injury.
- An acute onset of a change in a pre-existing spinal subluxation based on objective findings.

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