

Home Health Services

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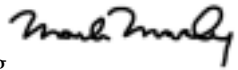
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MEMORANDUM

DATE: January 9, 2006

TO: Wisconsin Medicaid Home Health Agencies, HMOs, and other Managed Care Organizations

FROM: Mark B. Moody, Administrator 
Division of Health Care Financing

SUBJECT: Introducing the Wisconsin Medicaid Home Health Services Handbook

The Division of Health Care Financing (DHCF) is pleased to provide you with a copy of the Home Health Services Handbook. This handbook is a guide to Wisconsin Medicaid for all Medicaid-certified home health agencies. Providers should maintain and refer to this handbook in conjunction with the All-Provider Handbook.

This handbook incorporates current Wisconsin Medicaid policies related to home health agencies into a single reference source. The handbook completely replaces the Wisconsin Medical Assistance Program Provider Handbook, Part L, Divisions I and II. The handbook also replaces the following service-specific *Wisconsin Medicaid and BadgerCare Updates*:

- August 2005 *Update* (2005-57), Wisconsin Medicaid Issues Prior Authorization Home Care Attachment for Home Health and Private Duty Nursing Services.
- June 2004 *Update* (2004-48), Wisconsin Medicaid Covers Pneumococcal Vaccinations by Home Health Agencies in Addition to Influenza Vaccine.
- February 2004 *Update* (2004-08), Submitting claims with start-of-shift modifiers for home care services.
- August 2003 *Update* (2003-83), Changes to local codes, paper claims, and prior authorization for home health services, including private duty nursing and respiratory care services, as a result of HIPAA.
- June 2003 *Update* (2003-33), Discontinued home health procedure codes for private duty nursing.
- September 2000 *Update* (2000-33), Home care coverage determination software for Windows.
- April 1999 *Update* (99-13), Wisconsin Medicaid revises private duty nursing prior authorization guideline.
- May 1998 *Update* (98-15), Prior Authorization Request Charges for Home Health and Personal Care Agencies.
- July 1996 *Update* (96-27), Home Health Services: Reimbursement and Recipient Information Confidentiality.
- June 1996 *Update* (96-20), Flu Vaccinations.
- November 1995 *Update* (95-49), Home Health Reimbursement Limits and Other Changes.
- October 1995 *Update* (95-36), Home Health Changes for Medication Management.
- June 1995 *Update* (95-20), PRN Visits — Changes in Prior Authorization Procedures and Guidelines.

This handbook does *not* replace the all-provider publications, the Wisconsin Administrative Code or Wisconsin Statutes. Subsequent changes to policies affecting home health agencies will be published first in *Updates* and later in Home Health Services Handbook revisions.

Additional Copies of Publications

The Wisconsin Medicaid Web site, dhfs.wisconsin.gov/medicaid/, contains additional information for home health agencies, all *Updates* and electronic versions of the Home Health Services Handbook and the All-Provider Handbook.

Providers who have questions about the information in this handbook may call Provider Services at (800) 947-9627 or (608) 221-9883.

The DHFS would like to thank representatives from the Home Care Advisory Committee for reviewing this handbook.

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Contacting Wisconsin Medicaid

Web Site <i>dhfs.wisconsin.gov/</i>	
The Web site contains information for providers and recipients about the following: <ul style="list-style-type: none"> • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets. 	Available 24 hours a day, seven days a week
Automated Voice Response System (800) 947-3544 (608) 221-4247 	
The Automated Voice Response system provides computerized voice responses about the following: <ul style="list-style-type: none"> • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information. 	Available 24 hours a day, seven days a week
Provider Services (800) 947-9627 (608) 221-9883 	
Correspondents assist providers with questions about the following: <ul style="list-style-type: none"> • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification. 	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing Electronic Data Interchange Helpdesk (608) 221-9036 e-mail: <i>wiedi@dhfs.state.wi.us</i> 	
Correspondents assist providers with <i>technical</i> questions about the following: <ul style="list-style-type: none"> • Electronic transactions. • Companion documents. • Provider Electronic Solutions software. 	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk (608) 221-9730	
Correspondents assist providers with Web PA-related <i>technical</i> questions about the following: <ul style="list-style-type: none"> • User registration. • Passwords. • Submission process. 	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services (800) 362-3002 (608) 221-5720 	
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: <ul style="list-style-type: none"> • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns. 	Available 7:30 a.m. - 5:00 p.m. (M-F)

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Preface

This Home Health Services Handbook is issued to all Medicaid-certified home health services providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of the All-Provider Handbook for information about state-contracted managed care organizations.

Handbook Organization

The Home Health Services Handbook consists of the following chapters:

- Provider Information.
- Covered Services and Related Limitations.
- Medication Management and Administration.
- Covered Skilled Nursing Services.
- Covered Home Health Aide Services.
- Plan of Care.
- Prior Authorization.
- Claims Submission.
- Codes for Prior Authorization and Claims.

All-Provider Handbook

All Medicaid-certified providers receive a copy of the All-Provider Handbook, which includes the following sections:

- Certification and Ongoing Responsibilities.
- Claims Information.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Informational Resources.
- Managed Care.
- Prior Authorization.
- Recipient Eligibility.

Providers are required to refer to the All-Provider Handbook for information about these topics.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- dhfs.wisconsin.gov/medicaid/.
- dhfs.wisconsin.gov/badgercare/.

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

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 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
 - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
 - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

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Provider Information

This Home Health Services Handbook contains information regarding Wisconsin Medicaid's policies for the following services provided by home health agencies:

- Home health skilled nursing services.
- Private duty nursing (PDN) services.
- Home health aide services.
- Home health therapy services.
- Durable medical equipment (DME).
- Disposable medical supplies (DMS).

In addition, home health agencies that provide personal care services are also required to follow the policies and procedures as stated in Medicaid personal care services publications.

Scope of Services

The following laws and regulations provide the legal framework for the program requirements of home health agencies as stated in this handbook:

- Sections 49.46(2)(b)6m, 49.47(6)(a)1, 448.05, and 448.07, Wis. Stats.
- Chapters HFS 105.16, 107.11, 107.113, 107.12, and 133 and N 6.03 and 6.04, Wis. Admin. Code.

Home health agencies are reimbursed only for the specific services for which they are licensed.

Wisconsin Medicaid Certification Requirements

A home health agency is required to be certified by Wisconsin Medicaid to be eligible for reimbursement by Wisconsin Medicaid for providing services. A certification packet for home health agency providers may be obtained on the Wisconsin Medicaid Web site.

To obtain Wisconsin Medicaid certification, a home health agency is required to meet all of the following as stated in HFS 105.16, Wis. Admin. Code:

- Be certified to participate in Medicare as a home health agency.
- Be licensed pursuant to HFS 133, Wis. Admin. Code.
- Provide part-time, intermittent skilled nursing services performed by a registered nurse or licensed practical nurse and home health aide services. Agencies may also provide other home health services such as physical therapy, occupational therapy, speech and language pathology, DMS, and DME.
- All home health services must be provided in the recipient's home. Services may not be provided in a hospital or nursing home.
- All home health services must be provided in accordance with orders from the recipient's physician in a written plan of care that the physician reviews, dates, and signs at least every 62 days or when the recipient's medical condition changes, whichever occurs first.

In addition, home health agency responsibilities, as specified in HFS 105.16, Wis. Admin. Code, must be followed in order to maintain Wisconsin Medicaid certification.

Home health agencies with multiple locations should refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for additional certification information.

No separate certification is necessary for a Medicaid-certified home health agency to provide PDN, DME, DMS, or enteral nutrition products and supplies. However, providers are required to notify Wisconsin Medicaid in writing to receive applicable policy and billing

A home health agency is required to be certified by Wisconsin Medicaid to be eligible for reimbursement by Wisconsin Medicaid for providing services.

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information if DME or DMS are provided. Written notification must be sent to the following address:

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

Medicaid program requirements may not be construed to supersede the provisions for registration or licensure under s. 50.49, Wis. Stats. Refer to the Department of Regulation and Licensing Web site at drl.wi.gov/ and the Department of Health and Family Services Licensing and Permitting Web site at dhfs.wisconsin.gov/licensing.htm for more information about registration and licensure requirements.

Provider Certification for Personal Care Services

Home health agencies that provide personal care services in addition to home health services are required to indicate this information during the certification process. Providers should refer to the Personal Care Handbook for further information about providing personal care services.

Provider Certification for Private Duty Nursing for Ventilator-Dependent Recipients

To be eligible for reimbursement from Wisconsin Medicaid for PDN services provided to ventilator-dependent recipients residing at home, home health agencies are required to indicate in their request for certification their interest in providing this service. Providers are also required to submit the Wisconsin Medicaid Program Respiratory Care Services Affidavit, which can be found in the certification packet for home health agency providers.

Recipient Eligibility for Wisconsin Medicaid

Providers should always verify a recipient's eligibility before delivering services, both to determine eligibility for the requested date(s) of service and to discover any limitations to the recipient's coverage. The Medicaid Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways. Refer to the Contacting Wisconsin Medicaid page at the beginning of this handbook for more information about accessing the EVS.

Limited Benefit Categories

Some Medicaid recipients covered under special benefits categories have limited coverage. The EVS identifies recipients with limited benefits. Providers may refer to the All-Provider Handbook for more information on the different special benefits categories.

Copayment

Home health services, PDN services, including PDN for ventilator-dependent recipients, and personal care services are not subject to recipient copayment.

Universal Precautions

All caregivers providing services are required to follow universal precautions for each recipient for whom services are provided. It is recommended that all caregivers are required to have the necessary orientation, education, and training in the epidemiology, modes of transmission, and prevention of transmissible infections.

To be eligible for reimbursement from Wisconsin Medicaid for PDN services provided to ventilator-dependent recipients residing at home, home health agencies are required to indicate in their request for certification their interest in providing this service.

Written Statement of Recipient Rights

The rights held by all Wisconsin Medicaid recipients are listed in the All-Provider Handbook.

In accordance with HFS 133.08(2), Wis. Admin. Code, all home health agencies are required to furnish a written statement of recipient rights to the recipients they serve. Providers are required to share the statement with the recipient or their legal representative prior to providing services.

The recipient or legal representative is required to acknowledge the receipt of the statement of recipient rights in writing and the statement must be included in the recipient's medical record.

The rights held by all Wisconsin Medicaid recipients are listed in the All-Provider Handbook. Each recipient of home health services has rights that include, but are not limited to, the following:

- Being fully informed of all of his or her rights.
- Being fully informed of all rules and regulations governing recipient responsibilities.
- Being informed of all services and any changes in these services as they occur.
- Being informed of all charges for which the recipient may be responsible.
- Being fully informed of one's own health condition, unless medically contraindicated.
- Participating in the planning of services, including referral to health care institutions or other agencies.
- Refusing to participate in experimental research.
- Refusing treatment to the extent permitted by law and being informed of the medical consequences of such refusal.
- Confidential treatment of personal and medical records and approving or refusing their release to any individual outside the agency except in the case of transfer to a health care facility or as required by law or third-party payment contract.

- Being treated with consideration, respect, and full recognition of dignity and individuality.
- Being taught the treatment that is required so that the recipient can, to the extent possible, help himself or herself. Family, other persons living with the recipient, or other parties designated by the recipient will also be taught the treatment so that these persons can understand and assist the recipient.
- Complaining about the care that was provided or not provided, and seeking resolution of the complaint without fear of recrimination.

Distribution of Private Duty Nursing Information

Home health agencies providing PDN services are strongly encouraged to photocopy and distribute the brochure titled *Wisconsin Medicaid Private Duty Nursing — A Guide for Wisconsin Medicaid Recipients and Their Families* (refer to Appendix 2 of this handbook for a copy of the brochure) to all recipients and their families. The brochure helps providers explain the following:

- The extent and limitations of the PDN benefit.
- The Medicaid prior authorization process.
- The rights and responsibilities of PDN recipients and their families.
- The course of action available to recipients and their families who are dissatisfied with PDN services covered under Wisconsin Medicaid.

Discharge of Recipients

A home health agency may not discharge a recipient for any reason until the agency has discussed the details of the discharge with the recipient or the recipient's legal representative, and the recipient's physician. Refer to HFS 133.09, Wis. Admin. Code, for details concerning the discharge of recipients.

Availability of Records

Wisconsin Medicaid requires all providers to maintain a recipient's original medical record or a copy that can be reproduced.

To ensure continuity of care, providers are strongly encouraged to leave a copy of the recipient's original medical record in the recipient's home. Providers should also make a copy of the medical record available at the request of the recipient or the recipient's legal representative. Recipients have a right to a copy of their medical records and are not responsible for maintaining the agency's copy of their records.

Wisconsin Medicaid Review

Home health providers are required to make documentation and financial records available to Wisconsin Medicaid for review upon request in accordance with HFS 105.16(9), Wis. Admin. Code. Examples of these types of records include, but are not limited to, the following:

- Clinical notes.
- Personnel files.
- Plans of care.
- Prior authorization requests.
- Progress notes.
- Protocols.
- Timesheets.

As part of a Wisconsin Medicaid review, Wisconsin Medicaid may contact recipients who have received or are receiving services from a home health provider. Providers are required to provide any identifying information about the recipient requested by Wisconsin Medicaid. Medicaid personnel may visit a chosen recipient with the recipient's or legal representative's approval. The recipient has the opportunity to have any person he or she chooses present during the visit. Wisconsin Medicaid may investigate any complaint that is received concerning the provision of services by a provider.

Termination of a Provider's Certification

Wisconsin Medicaid may terminate a provider's Wisconsin Medicaid certification for failure to comply with the certification and covered services requirements specified in the following:

- HFS 105.16, Wis. Admin. Code.
- HFS 107.11, Wis. Admin. Code.
- HFS 107.113, Wis. Admin. Code.
- HFS 107.12, Wis. Admin. Code.

In addition, a provider's Medicaid certification may be terminated for any of the reasons described in HFS 106.06, Wis. Admin. Code.

In accordance with HFS 106.065(1)(c), Wis. Admin. Code, providers terminated for failure to comply with these requirements have 30 calendar days from the date of termination of certification to make alternative care arrangements for Medicaid recipients under their care prior to the effective date of termination. After the 30-day period, Wisconsin Medicaid payment for services will stop, except for payments to providers terminated in situations where the recipient's health and/or safety is in immediate jeopardy.

Wisconsin Medicaid is required to provide advance notice of termination of at least 15 working days to the provider, except in situations where the recipient's health and/or safety is in immediate jeopardy. In these situations, Wisconsin Medicaid provides at least five calendar days advance notice to the provider, as specified in HFS 106.065(1)(b), Wis. Admin. Code. As determined by Wisconsin Medicaid, Medicaid may also make alternative care arrangements to provide continuity of care and protect the recipient, as stated in HFS 106.065(1)(c), Wis. Admin. Code.

To ensure continuity of care, providers are strongly encouraged to leave a copy of the recipient's original medical record in the recipient's home.

Covered Services and Related Limitations

Wisconsin Medicaid reimburses certified home health agencies for medically necessary home health services as defined by HFS 101.03(96m), Wis. Admin. Code, provided to eligible recipients when prescribed by a physician. Wisconsin Medicaid requires that all services be medically necessary and appropriate to the diagnosis and medical condition of the recipient.

Home health agency providers will only be reimbursed for covered services provided by agency staff who are properly trained, as indicated by licensure, certification, or other documentation of training in the provider's personnel file.

Place of Residence

Home health services are covered by Wisconsin Medicaid only when they are performed at the recipient's place of residence.

Wisconsin Medicaid considers a recipient's home or residence to be the place where the recipient makes his or her home. The recipient's residence may be a single family home or an apartment unit. The recipient may reside with other household members. Hospital inpatient and nursing facilities are not allowable places of service while the recipient is receiving home health services.

The residence may be a community-based residential facility (CBRF); however, home health services may not exceed the limits established in chapter HFS 83, Wis. Admin. Code, and may not duplicate services that the CBRF is being paid to provide.

The following home health services are covered for recipients when the services are medically necessary and the recipient requires a considerable and taxing effort to leave the residence or cannot reasonably obtain these services outside the residence:

- Home health skilled nursing.
- Physical therapy (PT).
- Occupational therapy (OT).
- Speech and language pathology (SLP).

A recipient may receive private duty nursing (PDN) services and home health aide services from a home health agency without any limitations on his or her homebound status. However, home health aide services must be provided only in the recipient's place of residence.

Home Health Skilled Nursing Services

Recipient Eligibility for Home Health Skilled Nursing Services

According to HFS 107.11(2), Wis. Admin. Code, a recipient is eligible for home health skilled nursing services if he or she:

- Requires less than eight hours of direct, skilled nursing services in a 24-hour period according to the plan of care (POC).
- Does not reside in a hospital or nursing facility.
- Requires a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence.

Home health services are covered by Wisconsin Medicaid only when they are performed at the recipient's place of residence.

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Hours of Care That Qualify as Home Health Skilled Nursing Services

To determine if a recipient receives less than eight hours of direct skilled nursing services, add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends. If this adds up to *less* than eight hours, the recipient may be eligible for home health skilled nursing services.

If the recipient requires eight or *more* hours of direct skilled nursing services in a 24-hour period, he or she may be eligible for PDN services. A recipient cannot be eligible for both home health skilled nursing services and PDN services. Refer to “Private Duty Nursing Services” in this chapter for further information.

Place of Service

Services must be provided in the recipient’s place of residence to be covered home health skilled nursing services.

Home Health Skilled Nursing Visits

Wisconsin Medicaid reimburses only two types of home health skilled nursing visits:

- *Home Health Skilled Nursing Initial Visit* — the recipient’s first home health skilled nursing visit of any duration by a registered nurse (RN) or licensed practical nurse (LPN) in a calendar day. Only one initial visit is reimbursable per calendar day per recipient, regardless of the number of providers.
- *Home Health Skilled Nursing Subsequent Visit* — each additional home health skilled nursing visit of any duration following the initial visit per calendar day.

A visit begins when the RN or LPN enters the residence to provide a covered service. The visit ends when the RN or LPN leaves the residence at the conclusion of the covered service.

A visit made by a skilled nurse solely to train other home health providers is not a covered service. The home health agency is responsible for ensuring that its providers are properly trained to perform any service it furnishes. The cost of a skilled nurse’s visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

Skilled Nursing Services

In determining whether a service is skilled (i.e., requires the skills of an RN or LPN), providers should consider the inherent complexity of the service, the condition of the recipient, and accepted standards of medical and nursing practice. Some services are classified as skilled nursing services on the basis of the complexity of the services alone, such as intravenous and intramuscular injections or insertion of catheters. However, the recipient’s condition may be such that a service that would ordinarily be considered unskilled may be considered a skilled nursing service because the service can only be safely and effectively provided by a nurse.

Agencies should be aware that while some services may be provided by a licensed nurse, they may not be considered a covered service by Wisconsin Medicaid. For example, nonskilled services provided by a nurse due to the unavailability of a home health aide or personal care worker (PCW) to provide the nonskilled services, regardless of the importance of the services to the recipient, are not reimbursable as skilled nursing services.

Examples of Circumstances in Which Skilled Nursing May Be Required

There may be circumstances in which skilled nursing services may be required for services that might ordinarily be considered unskilled care. For example:

- A broken leg does not necessarily indicate a need for skilled care. However, if the recipient has a pre-existing circulatory condition, skilled nursing services may be

If the recipient requires eight or *more* hours of direct skilled nursing services in a 24-hour period, he or she may be eligible for PDN services.

needed to check for complications, to monitor medication administration for pain control, and to teach proper ambulation techniques to ensure proper bone alignment and healing.

- The condition of a recipient who has irritable bowel syndrome or who is recovering from rectal surgery may be such that only a nurse can safely and effectively give the recipient an enema. If the enema is necessary to treat the medical condition, the visit may be covered as a skilled nursing visit.

However, a service that, by its nature, requires the skills of a licensed nurse to be provided safely and effectively, continues to be a skilled service even if it is taught to the recipient, the recipient's family, or other caregivers. For example, if a recipient is discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day, the care is considered skilled nursing care, even if the family is taught to perform the care and provides it part or all of the time.

Supervision

In accordance with licensure requirements and as stated in ch. N 6, Wis. Admin. Code, LPNs are required to be supervised by an RN or a physician.

Ongoing supervision of a home health aide, LPN, or PCW must be provided in accordance with HFS 105.16(2)(b), Wis. Admin. Code.

Supervisory visits must include:

- A review and evaluation of the recipient's medical condition and medical needs according to the written POC during the period in which agency care is being provided.
- An evaluation of the appropriateness of the relationship between the direct care giver and the recipient.
- An assessment of the extent to which the recipient's goals are being met.

- A determination of whether or not the current level of home health services provided to the recipient continues to be appropriate to treat the recipient's medical condition.
- A determination of whether or not the services are medically necessary.
- A discussion and review with the recipient about the services received by the recipient.

After each supervisory visit, the RN must discuss the results of the supervisory visits with the home health aide, LPN, or PCW. The results of each supervisory visit must be documented in the recipient's medical record.

Separate reimbursement for supervisory visits is limited to PCW supervisory visits. Refer to personal care services publications for specific information on the supervision of PCWs.

Private Duty Nursing Services

Recipient Eligibility for Private Duty Nursing Services

According to HFS 107.12(1)(a), Wis. Admin. Code, a recipient is eligible for PDN services if he or she:

- Requires a total of eight or more hours of direct skilled nursing services in a 24-hour period according to the POC.
- Does not reside in a hospital or nursing facility.
- Has a written POC specifying the medical necessity for PDN services.

Hours of Care That Qualify as Private Duty Nursing Services

To determine if a recipient receives eight or more hours of direct skilled nursing services, add up the total hours of direct skilled nursing care provided by all caregivers, including home health agencies, independent nurses, and skilled cares provided by family or friends. If the total time required for these cares is equivalent to eight or more hours, the recipient is eligible for

In accordance with licensure requirements and as stated in N 6, Wis. Admin. Code, LPNs are required to be supervised by an RN or a physician.

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PDN. Wisconsin Medicaid requires that the POC include the actual amount of time to be spent on medically necessary direct cares that require the skills of a licensed nurse.

For this purpose, skilled nursing services covered by Wisconsin Medicaid may include, but are not limited to, the following:

- Injections.
- Intravenous feedings.
- Gastrostomy feedings (include the time needed to begin, disconnect, and flush — not the entire time the feeding is dispensing).
- Nasopharyngeal and tracheostomy suctioning.
- Insertion and sterile irrigation of catheters.
- Application of dressings involving prescription medications and aseptic techniques.
- Treatment of extensive decubitus ulcers or other widespread skin disorders.

Reasonable time for record keeping, travel, staff training, supervision, and case management are allowable costs that have been included in the rates established for PDN hours. Therefore, the time spent on these activities is not separately reimbursable.

If the recipient requires fewer than eight hours of direct skilled nursing services in a 24-hour period, he or she may be eligible for home health skilled nursing services. A recipient cannot be concurrently eligible for both PDN and intermittent part-time skilled visits provided by nurses. Refer to “Home Health Skilled Nursing Services” in this chapter for further information.

Place of Service for Private Duty Nursing Recipients

As stated in HFS 107.12(1)(a), Wis. Admin. Code, recipients who are authorized to receive PDN services in the home may make use of approved hours of service outside the home setting during those hours when a recipient’s normal life activities take him or her outside the home setting.

Ventilator-Dependent Recipients

In accordance with HFS 107.113(1), Wis. Admin. Code, a ventilator-dependent recipient is eligible for respiratory care when he or she meets all of the criteria for PDN services and meets the following requirements:

- Is medically dependent on a ventilator for life support at least six hours per day. In addition, the recipient is required to meet one of the following two conditions:
 - ✓ Has been hospitalized for at least 30 consecutive days for his or her respiratory condition. The 30 consecutive days may occur in more than one hospital or nursing facility.
 - ✓ If the recipient has been hospitalized for less than 30 days, the recipient’s eligibility for services will be determined by the Division of Health Care Financing Chief Medical Officer on a case-by-case basis. The Chief Medical Officer’s determination may include discussions with the recipient’s pulmonologist and/or primary care physician to evaluate the recipient’s diagnosis, prognosis, history of hospitalizations for the respiratory condition, and weaning attempts, when appropriate.
- Has adequate social support to be treated at home and desires to be treated at home.
- May have ventilator care safely provided at home.

Private Duty Nursing Services Reimbursement Requirements

Wisconsin Medicaid reimburses PDN services as part of the PDN benefit if the services:

- Meet Wisconsin Medicaid’s criteria to be classified as PDN services.
- Are prior authorized.
- Are prescribed by a physician in accordance with s. 49.46(2), Wis. Stats.

Reasonable time for record keeping, travel, staff training, supervision, and case management are allowable costs that have been included in the rates established for PDN hours.

Only RNs and LPNs may provide PDN services to ventilator-dependent recipients.

- Are provided to recipients eligible under s. 49.47(6)(a), Wis. Stats.
- Are implemented according to HFS 107, Wis. Admin. Code.
- Are provided in accordance with the recipient's POC. Services provided to the recipient that are not on the POC are not covered services. Refer to the Plan of Care chapter of this handbook for more information.

Private Duty Nursing Services Providers

Only RNs and LPNs can provide PDN. The following PDN services can only be performed by an RN:

- The initial evaluation visit.
- Initiating the physician's POC and any necessary revisions.
- Providing those services that require the care of an RN as defined in ch. N 6, Wis. Admin Code.
- Initiating appropriate preventive and rehabilitative procedures.
- Regularly evaluating the recipient's needs.

Nursing services not requiring an RN may be provided by an LPN under the supervision of an RN. An LPN's duties include the following:

- Performing nursing acts delegated by an RN under ch. N 6.03, Wis. Admin. Code.
- Assisting the recipient in learning appropriate self-care techniques.
- Meeting the nursing needs of the recipient according to the written POC. All nursing acts performed must be within the professional scope of practice for the LPN.

In accordance with HFS 105.16(10)(a)3, Wis. Admin. Code, both RNs and LPNs are required to do the following:

- Arrange for or provide health care counseling within the scope of nursing practice to the recipient and the recipient's

family in meeting the needs related to the recipient's condition.

- Provide coordination of care for the recipient, including ensuring that provision is made for all required hours of care for the recipient.
- Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience.
- Within 24 hours of providing service, prepare written clinical notes that document the care provided and incorporate them into the recipient's medical record within seven days.
- Promptly inform the physician and other personnel participating in the recipient's care of changes in the recipient's condition and needs.

Providing Services to Ventilator-Dependent Recipients

Only RNs and LPNs may provide PDN services to ventilator-dependent recipients. The provider is required to document that the appropriate home health agency staff are qualified to perform all of the following services:

- *Tracheostomy care.* Stoma care, suctioning, humidification, changing a tracheostomy tube, and emergency procedures for tracheostomy care.
- *Oxygen therapy.* Operation of oxygen systems and auxiliary oxygen devices, and written documentation of the recipient's oxygen needs.
- *Operation and interpretation of monitoring devices.* Types of cardio-respiratory monitoring, pulse oximetry, and capnography.
- *Operation of ventilators.* Positive pressure or negative pressure ventilation.
- *Other respiratory therapies.* Continuous positive airway pressure, chest physiotherapy, respiratory assessment, and operation of aerosol and humidity devices.

- *Pulmonary rehabilitation.* Maintenance and restoration of the recipient's physical functioning, modification of the recipient's immediate living environment, assessment of the recipient's activities of daily living.

Recipient Medical Record for Private Duty Nursing Services

Home health agencies are required to maintain a medical record for each recipient receiving PDN services as stated in HFS 105.16(10)(d), Wis. Admin. Code. The record must document the nature and scope of all services provided and be systematically organized and readily accessible to Wisconsin Medicaid. The medical record must include all of the following:

- Recipient identification information.
- The recipient's condition, problems, progress, and all services rendered.
- Appropriate hospital information supplied by the hospital, including discharge information, diagnosis, current patient status, and post-discharge POC.
- An admission evaluation and assessment of the recipient.
- All medical orders, including the current physician written POC and all interim physician's orders. Refer to the Plan of Care chapter of this handbook for further information about a physician's verbal orders.
- A consolidated list of medications, including start and stop dates, dosage, route of administration, and frequency. This list must be reviewed and updated for each nursing visit, if necessary.
- Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. A "progress note" is a written notation, timed, dated, and signed by a member of the health team providing covered services, that summarizes facts

about the care furnished and the recipient's response during a given period of time.

- Clinical notes written, timed, signed, and dated the day service is provided and incorporated into the medical record within seven days. A copy of these notes should be maintained in the record in the recipient's home. These notes are a notation of contact with a recipient that documents the PDN services provided and should do the following:
 - ✓ Describe the recipient's medical status, including signs and symptoms.
 - ✓ List the time and date of the contact, a description of treatment and drugs administered, and the recipient's reaction.
 - ✓ Describe any changes in the recipient's physical or emotional condition and any nursing intervention.

Nurses are encouraged to write clinical notes as services are provided and complete them by the end of each shift. These notes should be utilized by nurses performing services during subsequent shifts in order to maintain continuity of care.

- Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days.

The following information must be included in the documentation concurrent to the notation of service in both progress notes and clinical notes:

- The date and time of service.
- The signature and title of the performing provider.

All physician-ordered treatments and interventions included in the POC must be documented in the recipient's medical record.

Home health agencies are required to maintain a medical record for each recipient receiving PDN services as stated in HFS 105.16(10)(d), Wis. Admin. Code.

For ventilator-dependent recipients, the ventilator settings, parameters, and the ventilator checks must also be documented in the recipient's medical record at least for each nurses' shift.

Emergency Procedures

As required by HFS 105.16(10)(e), Wis. Admin. Code, all agencies providing PDN are required to have the following back-up and emergency procedures in place:

- Have identified another nurse on the case as a backup to provide services to the recipient in the event the scheduled nurse is temporarily unable to provide services. Providers are required to inform recipients of the backup nurse's name before the backup nurse provides services.
- Have a written plan for recipient-specific emergency procedures in the case of a life-threatening situation, fire, or severe weather warnings. Home health agencies are required to give this plan to the recipient and all caregivers prior to the initiation of these procedures.
- Take appropriate action in the case of any significant accident, injury, or adverse change in the recipient's condition. Nurses are required to immediately notify the recipient's physician, guardian (if any), and any other responsible person designated in writing by the recipient or recipient's legal representative.

Home Health Aide Services

Home health aide services are services necessary to maintain the recipient's health or to facilitate treatment of the recipient's medical condition. Home health aide services must include at least one medically necessary delegated nursing act per visit, which can be safely performed by a home health aide, but

cannot be safely performed by a PCW as determined by the delegating RN (HFS 107.11[2][b], Wis. Admin. Code). Providers should refer to the Wisconsin Medicaid Personal Care Handbook for further information regarding the use of personal care services.

Place of Service

Services must be provided in the recipient's residence to be covered home health aide services.

Home Health Aide Services Providers

Home health aides are required to be trained according to requirements issued by the Bureau of Quality Assurance. The completion of training and demonstration of competency to perform each assigned task should be documented in the home health aide's personnel record.

An RN, a physical therapist, an occupational therapist, or a speech-language pathologist is required to prepare written instructions for recipient services provided by a home health aide, as appropriate. Instructions may include duties, delegated nursing acts, a home therapy program, assistance with a recipient's activities of daily living, and household tasks incidental to direct care.

Delegation of Tasks

Each home health aide task must be specifically assigned by an RN. The RN must determine that the home health aide is trained to perform each task in a manner that will not jeopardize the recipient's health. A home health aide may not be assigned to any task for which he or she is not trained.

Note: Registered nurses may only delegate *nursing* acts to a home health aide. A *medical* act that has been delegated to an RN by a physician may not be re-delegated by the RN to any other provider.

Home health aide services must include at least one medically necessary delegated nursing act per visit, which can be safely performed by a home health aide, but cannot be safely performed by a PCW as determined by the delegating RN (HFS 107.11[2][b], Wis. Admin. Code).

In accordance with ch. N 6.03(3), Wis. Admin. Code, an RN should do all of the following in the supervision and direction of delegated nursing acts:

- Delegate tasks commensurate with education preparation and demonstrated abilities of the person supervised.
- Provide direction and assistance to those supervised.
- Observe and monitor the activities of those supervised.
- Evaluate the effectiveness of acts performed under supervision.

Home health agencies must document that these conditions are met when nursing acts are delegated to home health aides.

Home Health Aide Visits

Within home health aide services, Wisconsin Medicaid reimburses for only two types of home health visits:

- *Home Health Aide Initial Visit.* The recipient's first home health aide visit in a calendar day. For Wisconsin Medicaid purposes, an initial visit may last up to four hours. Only one home health aide initial visit is reimbursable per calendar day per recipient, regardless of the number of providers.
- *Home Health Aide Subsequent Visit.* Each additional home health aide visit following the initial visit per calendar day. For Wisconsin Medicaid purposes, a home health aide subsequent visit may last up to three hours.

A visit begins when the home health aide enters the residence to provide a covered service. The visit ends when the home health aide leaves the residence.

Upon completion of the covered service, additional visits per day may be covered only when necessary. Additional visits must only be

used to provide medically necessary time-specific tasks, tasks that could not feasibly be provided in one visit, or when the provider obtains prior authorization (PA) for continuous visits. Examples of time-specific tasks include:

- Helping the recipient in and out of bed using a hoist lift.
- Scheduled G-tube feedings.

Maximizing Home Health Aide Visits

The time spent at home health aide visits must be maximized whenever possible before scheduling additional home health aide visits or personal care visits.

All cares that can be fulfilled utilizing the allotted four hours for an initial visit or the allotted three hours for a subsequent visit should be performed during that scheduled visit. Scheduling a subsequent visit or personal care visit later in the same day to complete cares that could have been completed during a previous visit that day would not be considered medically necessary because the previous visit was not maximized.

In addition, when case sharing with a personal care agency, home health aide visits must be maximized whenever possible before a PCW begins providing care. The home health aide should perform all personal cares in addition to the delegated nursing acts during the visit.

Continuous Visits

All home health aide visits in excess of four hours must be prior authorized if the agency wishes to bill for more than one visit. These home health aide visits are referred to as continuous visits. Continuous visits may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to a recipient's medical condition. Immediate attention is classified as needing service within five minutes, leaving inadequate time for the recipient to call in a home health aide. The intervention must include a delegated nursing act.

The time spent at home health aide visits must be maximized whenever possible before scheduling additional home health aide visits or personal care visits.

A therapy evaluation must be completed prior to the development of a therapy POC.

When continuous visits of four or more hours are medically necessary, providers may bill for more than one visit when the visits have been prior authorized. Providers may not bill multiple visits for continuous home health aide visits without PA. Providers are required to request PA for continuous visits regardless of the 30-visit threshold.

Home Health Therapy Services

As stated in HFS 107.11(2), Wis. Admin. Code, Wisconsin Medicaid covers the following types of medically necessary skilled therapy services provided by a home health agency:

- Physical therapy.
- Occupational therapy.
- Speech and language pathology.

Home health therapy services are provided by physical therapists, occupational therapists, and speech-language pathologists through home health agencies. The therapy providers may be any of the following:

- Employed by the home health agency.
- Employed by an agency under contract with the home health agency.
- Independent providers under contract with the home health agency.

Wisconsin Medicaid requires therapy providers employed by, or under contract with, home health agencies to meet all Medicaid certification requirements, but does not require them to be individually certified by Wisconsin Medicaid. The home health agency is required to maintain records showing that its individual providers meet Medicaid requirements.

Place of Service

Wisconsin Medicaid therapy services provided through home health agencies must be provided in the recipient's place of residence except when federal regulations allow services to be provided elsewhere due to the need for special equipment.

Home Health Therapy Visits

A home health therapy visit is a visit of any duration by a physical therapist, occupational therapist, or speech-language pathologist for a period of therapy service. Only one PT visit, OT visit, and SLP visit, per recipient, per day, is reimbursable by Wisconsin Medicaid.

A visit begins when the therapy provider enters the residence to provide a covered service. The visit ends when the therapy provider leaves the residence.

A visit made by a therapy provider solely to train other home health providers is not a covered service. The home health agency is responsible for ensuring that its providers are properly trained to perform any service it furnishes. The cost of a skilled therapy provider's visit for the purpose of training home health agency providers is an administrative cost to the home health agency.

Supervision of Assistants

Wisconsin Medicaid requires a physical therapist, occupational therapist, or speech-language pathologist to be physically present at a recipient's residence to supervise an assistant. The supervising physical therapist, occupational therapist, or speech-language pathologist is required to be of the same therapy discipline as the assistant. The agency may bill for the services of either the physical therapist, occupational therapist, or speech-language pathologist or the assistant during any one visit; the agency may not bill for both professionals at the same time.

Therapy Evaluation

A therapy evaluation must be completed prior to the development of a therapy POC. The evaluation must be reviewed, signed, and dated by the performing therapy provider, who must be identified as such on the evaluation. The evaluation must include the comprehensive results of formal/informal tests and measurements that provide a baseline for the recipient's functional limitations from which a POC is established. The evaluation must

include written instructions for follow through or carryover by the recipient and/or caregiver. Carryover or follow through must be realistically achievable by the recipient and/or caregiver at the place of residence.

Therapy Plan of Care

A therapy POC must be completed prior to the provision of home health therapy services. The therapy POC must contain specific and measurable goals that are related to an identified deficit and are appropriate to the recipient's chronological or developmental age, way of life, and home situation. The therapy goals must be medical in nature, rather than educational, social, or vocational.

Medically Necessary Skilled Therapy Services

Services that may only be performed safely and effectively by a skilled physical therapist, occupational therapist, or speech-language pathologist are considered skilled therapy services. Wisconsin Medicaid will cover only skilled therapy services that are medically necessary. The skilled therapy services must be consistent with the nature and severity of the recipient's medical condition and functional status. The amount, frequency, and duration of the services must also be medically necessary and must not duplicate other services being provided.

The skilled therapy services must be provided with the expectation of *one* of the following outcomes, based on the physician's assessment of the recipient's rehabilitation potential:

- The condition of the recipient is expected to improve materially in a reasonable and generally predictable period of time.
- The services are necessary to the establishment of a safe and effective maintenance program.

Also, the recipient must show the following:

- Motivation, interest, or desire to participate in home health therapy. The frequency and amount of home health therapy should depend on the recipient's demonstrated response to current therapy and/or estimated response to proposed therapy.
- Progress toward meeting or maintaining established measurable goals or show carryover (follow-through of activities or skills learned) within six months of treatment at home.

The skilled therapy services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the recipient's condition.

Services of skilled therapy providers that are for the purpose of teaching the recipient or the recipient's family or caregivers necessary techniques, exercises, or precautions are covered to the extent that they are reasonable and necessary to treat the medical condition. Direct treatment must be provided during family or caregiver education session(s).

The therapy provider is required to provide a summary of all therapy activities, including goals and outcomes, to the recipient's physician at least every 62 days, and also upon the completion of therapy services to the recipient.

Cotreatment

Cotreatment (interdisciplinary treatment) is simultaneous treatment by two providers of different therapy disciplines during the same time period. If a recipient requires multiple therapies and each therapy has a unique approach to the recipient's treatment, the therapies should be separately and independently provided to give the recipient the maximum benefit and opportunity for rehabilitation. Refer to the Prior Authorization chapter of this handbook for PA requirements for cotreatment.

Services that may only be performed safely and effectively by a skilled physical therapist, occupational therapist, or speech-language pathologist are considered skilled therapy services.

Home Health Therapy Examples

The following are examples of reimbursable home health therapy visits:

Federal and state laws permit Wisconsin Medicaid to pay for home health skilled nursing services provided by a nurse in independent practice (NIP) *only* when no home health agency is available.

- A recipient with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition that has left her wheelchair bound and, for the first time, without any expectation of achieving ambulation again. The physician has ordered OT to select the proper wheelchair for her long-term use, to teach the recipient and her family safe use of the wheelchair and safe transfer techniques in her home. Occupational therapy would be reasonable and necessary to evaluate the recipient's overall needs, to make the selection of the proper wheelchair, and to teach the recipient and/or family safe use of the wheelchair, proper transfer techniques, and other self-care activities.
- A physician prescribes PT treatments three times a week for 45 days for a recipient who has been discharged from the hospital following a recent hip fracture. The recipient was discharged using a walker for seven days from the start of home care. The POC shows that the recipient was discharged from the hospital with restricted mobility in ambulation, transfers, and climbing of stairs. The recipient has an unsafe gait that indicates a need for gait training and the recipient had not been instructed in stair climbing and a home exercise program. The goal of the PT will be to increase strength and range of motion, to progress from walker to cane with safe gait, and to address stair climbing. The services are reasonable and necessary for the reimbursement of the recipient's medical condition.

Reimbursement Not Available

Home health agencies may not receive Medicaid reimbursement for the following:

- Activities for the general welfare of a recipient, e.g., general exercises to promote overall fitness or flexibility and

activities to provide diversion or general motivation do not constitute skilled therapy.

- Therapy that requires only the use of equipment without the skills of a therapy provider is not covered.
- Group therapy.

Home Health Services Provided by Nurses in Independent Practice

Federal and state laws permit Wisconsin Medicaid to pay for home health skilled nursing services provided by a nurse in independent practice (NIP) *only* when no home health agency is available. An NIP is required to have PA before providing home health services to a recipient.

The following conditions *must* be met before an NIP can submit claims to Wisconsin Medicaid for home health services:

- No home health agency is willing and able to provide care to the recipient. If an NIP submits claims to Wisconsin Medicaid, that nurse is required to submit documentation supporting this condition with the PA request. The NIP, the recipient, the recipient's family, or a discharge planner is first required to try to locate services by contacting *all* home health agencies serving the recipient's area.

Documentation must include the following:

- ✓ The name of each home health agency contacted.
- ✓ The name of the person contacted at the home health agency.
- ✓ The date and time of contact.
- ✓ Information the caller provided to the home health agency contact.
- ✓ A list of the questions the caller asked the home health agency contact.
- ✓ The responses the home health agency contact gave to the caller's questions.

- The services must be medically necessary.
- Recipient requires a considerable and taxing effort to leave the residence, or the recipient cannot reasonably obtain these services outside the residence or from a more appropriate provider.
- All rules in HFS 101-109, Wis. Admin. Code, must be followed. Home health services provided by an NIP are monitored after payment has been made. Payment for services that do not follow these guidelines will be recouped by Wisconsin Medicaid.

Case Sharing

If more than one type of Medicaid-certified home care provider provides care to a recipient, the case becomes a shared case. All home health agencies sharing a case with other home health agencies, personal care agencies, or NIP should document their communication with the other providers regarding recipient needs, POC, and scheduling. This will ensure coordination of services and continuity of care, while also preventing duplication of services being provided to a recipient.

According to HFS 101.03(96m)(b)(6), Wis. Admin. Code, medically necessary services cannot be duplicative with respect to other services being provided to the recipient. When providers of more than one service type share a case, home health agencies need to integrate that information into the recipient's POC and the PA request. Refer to the Prior Authorization chapter of this handbook for further information on case sharing of services provided by home health agencies.

Durable Medical Equipment

Durable medical equipment (DME) is equipment that can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

Durable medical equipment is covered only when prescribed by a physician. Covered services are limited to items contained in the Wisconsin Medicaid DME Index, accessible on the Wisconsin Medicaid Web site. Some items require PA. For further information, refer to Wisconsin Medicaid DME publications.

Disposable Medical Supplies

Disposable medical supplies (DMS) are medically necessary items that have a limited life expectancy and are consumable, expendable, disposable, or nondurable.

The cost of routine DMS used by providers while caring for the recipient, including routine DMS mandated by the Occupational Safety and Health Administration, is covered in the reimbursement rate for the service provided. All DMS covered in the reimbursement rate are not separately reimbursable. Home health agencies are expected to provide these supplies only during the billable hours in which they provide covered services. Providers are not expected to provide recipients with supplies for use when they are not directly providing covered services.

When Wisconsin Medicaid includes DMS in the reimbursement rate, providers may *not* do any of the following:

- Charge the recipient for the cost of DMS.
- Use supplies obtained by the recipient and paid for by Wisconsin Medicaid.
- Submit claims to Wisconsin Medicaid for the cost of the supplies.

Refer to Appendix 28 of this handbook for more information about providing DMS and a list of DMS included in the reimbursement rate.

All home health agencies sharing a case with other home health agencies, personal care agencies, or NIP should document their communication with the other providers regarding recipient needs, POC, and scheduling.

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about services that do not meet program requirements, noncovered services, and situations when it is permissible to collect payment from recipients for noncovered services.

Home health agencies may not receive Medicaid reimbursement for the services stated in HFS 107.11(5), Wis. Admin. Code. These services include, but are not limited to the following:

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

- Services that are not medically necessary as defined in HFS 101.03(96m), Wis. Admin. Code, including, but not limited to, services that are:
 - ✓ Duplicative with respect to other services provided.
 - ✓ Provided solely for the convenience of the recipient, recipient's family, or a provider.
 - ✓ Not cost-effective compared to an alternative medically necessary service that is reasonably accessible to the recipient.
- Any services that do not make effective and appropriate use of available services.
- More than one initial visit per day by a home health skilled nurse, home health aide, physical or occupational therapist or speech and language pathologist.
- Services requiring PA that are provided without PA.
- Supervision of the recipient when supervision is the only service provided at the time. This includes supervision provided to give the primary caregiver a respite from care.
- Hospice care provided under HFS 107.31, Wis. Admin. Code.
- Mental health and substance abuse services provided under HFS 107.13(2), (3), (3m), (4), and (6), Wis. Admin. Code.
- Medication administration by a PCW or a home health aide that has not been delegated by an RN according to the relevant provisions of HFS 133, Wis. Admin. Code.
- Home health skilled nursing services contracted by a home health agency unless the requirements of HFS 133.19, Wis. Admin. Code, are met and approved by Wisconsin Medicaid.
- Home health services to a recipient who is eligible for covered services under the Medicare program or any other insurance held by the recipient.
- Parenting.
- Services to other members of the recipient's household.
- Services provided to a recipient by legally responsible relatives in accordance with ch. 49.90, Wis. Stats.
- Skilled nursing visits solely for the purpose of ensuring that a recipient who has a demonstrated history of noncompliance over 30 days complies with the medications program, as required by HFS 107.11(5)(l)1, Wis. Admin. Code.

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M Medication Management and Administration

Medication Management

A medication management visit is a medically necessary visit in which a nurse provides medication management when the recipient is physically or cognitively unable to follow a medication program without assistance, and no other willing and able caregiver is available.

Only a nurse may provide medication management services for the recipient. The following tasks may be delegated by a registered nurse to either a home health aide or personal care worker (PCW):

- Assistance with medication administration.
- Medication administration other than by intramuscular or subcutaneous injection, nasogastric, or intravenous administration.

Providers cannot submit claims using procedure code T1502 (Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit) for medication assistance or administration provided by a home health aide or PCW. Refer to Appendix 19 of this handbook for a list of procedure codes.

Refer to the Covered Home Health Aide Services chapter of this handbook for further information about medication administration services provided by home health aides.

If skilled nursing services are provided in conjunction with medication management services, the visit is considered a home health skilled nursing visit.

Covered Services

A medication management visit may include the following services:

- Administering medication, other than intravenous, requiring the skills of a nurse when administration cannot be delegated safely to a home health aide or PCW.
 - ✓ Intravenous fluid or medication administration may be billed as a home health skilled nursing visit.
 - ✓ Intramuscular and subcutaneous injections are considered medication management visits. This includes sliding scale insulin injections.
- Prefilling syringes for self-injection when the recipient is not capable and a pharmacy is not available.
- Setting up medication for self-administration, administration, or assistance with administration by an unlicensed caregiver when the recipient is not capable and a pharmacy is not available. Medication set up includes changing medications, programming an electronic medication dispenser, and instructing the recipient about the medication program and use of the dispenser.
- Providing other services directly related to a medication program, such as teaching related to a recipient medication regimen, determined on a case-by-case basis.

Only a nurse may provide medication management services for the recipient.

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Reimbursement Not Available

Home health agencies may not receive Medicaid reimbursement for the following:

- A skilled nursing visit to ensure compliance with the medication regimen of an adult recipient who has a demonstrated history of non-compliance over 30 days.
- Medication administration to a minor child unless the parents are unable to administer the medication.
- A skilled nursing visit to administer medication to an adult recipient who is capable, but chooses not to, self-administer the medication. A recipient is considered “capable” if the recipient has no physical or mental condition that would prevent the recipient from self-administering the medication.

Coverage Guidelines

Medication management visits must adhere to the following guidelines:

- *All nursing services must be consolidated into one visit whenever possible.* A medication management visit may be billable on the same date of service as a home health skilled nursing visit or personal care supervisory visit when more than one visit is *medically necessary*.
- An ongoing assessment visit is not covered if the recipient has received a medication management visit within the past 62 days.
- The 30-visit home health prior authorization (PA) threshold includes medication management visits.
- If a recipient is unable to fill his or her own insulin syringes by the many methods available, prefilled insulin pens are not an appropriate alternative, and a pharmacy is unavailable to fill syringes, medication management visits to fill syringes may be authorized.
- Medication set up may be medically necessary to ensure the medication program is followed correctly, especially when a recipient is taking multiple prescriptions at various times during the day. It may also be necessary to allow safe delegation of administration to an unlicensed caregiver.
 - ✓ Alternatives to setting up medications, such as picture charts, color coding, and alarm caps, should be considered.
 - ✓ Medication set up is normally done on a biweekly basis. Requests for a more frequent set up schedule must be documented as medically necessary and will be determined on a case-by-case basis.
 - ✓ Any additional visit to set up missing medications is not covered because Wisconsin Medicaid only pays for a completed service, not a partial service. For example, if a medication was not reordered appropriately to completely fill out a recipient’s two-week planner, an additional visit to finish filling out the planner would not be covered.
- In some cases, a mix of home health skilled nursing visits and medication management visits is appropriate. To determine if a visit is for the purpose of medication management or home health skilled nursing, the provider should ask “If no medication management services were needed, would the visit otherwise qualify as a covered home health skilled nursing visit?”
- Medication management visits may be medically necessary and appropriate on a pro re nata (PRN) or “as needed” basis. Such PRN visits may be included in PA requests that include documentation that the request is reasonable. Refer to the Prior Authorization chapter of this handbook for further information on PRN visits.

A medication management visit may be billable on the same date of service as a home health skilled nursing visit or personal care supervisory visit when more than one visit is *medically necessary*.

Psychiatric Medication Management Visits

Medication management services for recipients with mental illness are generally provided under other Wisconsin Medicaid benefits.

Medication management services are provided as part of community support program (CSP) services; therefore they are not covered home health services for recipients receiving covered CSP services as stated in HFS 107.11(5)(h), Wis. Admin. Code. Refer to CSP publications for further information. Medication management services are also not covered home health services when these services are provided under outpatient psychotherapy and day treatment services, according to HFS 107.11(5)(h), Wis. Admin. Code.

Prior authorization requests must document information on a recipient's enrollment status in a CSP, day treatment, or other mental health service that can provide medication management services to the recipient.

All home health skilled nursing criteria apply when medication management services for mental health recipients are provided under home health services. This includes the following:

- The services are medically necessary and the recipient requires a considerable and taxing effort to leave the residence or cannot reasonably obtain these services outside the residence.
- The medication management service must meet the criteria of the home health benefit.

If providers are not certain what resources are available for a particular mental health recipient, contact the recipient's county community services board per ch. 51.42, Wis. Stats. This agency, as specified under ch. 51, Wis. Stats., is responsible for providing or arranging services for its citizens with mental health needs. Contact the recipient's county/tribal social or human services agency for the agency's contact information.

Medication Administration

Intravenous, Intramuscular, or Subcutaneous Injections and Infusions or Intravenous Feedings

Intravenous, intramuscular, or subcutaneous injections and infusions or intravenous feedings require the skills of a nurse to be performed safely and effectively. The medication being administered must be accepted as safe and effective treatment of the recipient's medical condition, and there must be a medical reason that the medication cannot be taken orally. With the exception of intravenous medications and infusions, these tasks are reimbursable only as medication management visits.

The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances that justify the need for additional injections.

Insulin Injections

Insulin injections by a nurse are not usually considered skilled nursing services. Insulin is customarily self-injected by recipients or injected by their families, although assistive devices may sometimes be required. However, the injections would be considered a reasonable and necessary skilled nursing service when a recipient cannot reasonably obtain services outside the residence, is either physically or mentally unable to self-inject insulin (even with the aid of assistive devices), and there is no other person who is able and willing to inject the recipient. These services are not covered by Wisconsin Medicaid when a recipient is eligible for insulin injections and other home health services through Medicare or another insurance provider.

Medication management services for recipients with mental illness are generally provided under other Wisconsin Medicaid benefits.

Vitamin B-12 Injections

Vitamin B-12 injections are considered specific therapy only for the following conditions:

- Alcohol neuropathies.
- Anastomosis or partial resection of small intestines.
- Anemia, fish tapeworm.
- Anemia, macrocytic.
- Anemia, megaloblastic.
- Anemia, pernicious.
- Anemia, post-bowel resection.
- Anemia, post-gastrectomy syndrome.
- Blind loop syndrome.
- Cancer of stomach, liver, intestines, and colon.
- Crohn's disease.
- Posterolateral sclerosis.
- Sprue or other malabsorption states.
- Strictures of small intestine.

Synagis® Injections

Synagis® injections are covered only when they are part of an already scheduled, covered skilled nursing visit, and there is a physician's order for the service. Wisconsin Medicaid does not reimburse for skilled nursing visits where the administration of Synagis® is the only purpose for the visit.

Tuberculosis Skin Test

Tuberculosis skin tests and the reading of those tests are covered only when they are part of an already scheduled, covered skilled nursing visit, and there is a physician's order for the service. Wisconsin Medicaid does not reimburse for skilled nursing visits when the administration of a tuberculosis skin test is the only purpose for the visit.

Oral Medications

The administration of oral medications to a recipient is not a reasonable or medically necessary skilled nursing service except when the complexity of the recipient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must

document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

Eye Drops and Topical Ointments

The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eye drops or ointments is necessary for the treatment of an illness or injury and the recipient cannot self-administer them and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. However, administration can be provided during a covered skilled nursing visit for observation and assessment of the recipient's condition.

Influenza and Pneumococcal Vaccinations

Home Vaccination

Home health agencies may administer the influenza and pneumococcal vaccines to recipients who they are currently serving when there is a physician order for the vaccination.

A nurse is required to administer the vaccine during an already scheduled home health skilled nursing visit. Wisconsin Medicaid does not reimburse for a home health skilled nursing visit if administration of the vaccination is the only purpose for the visit.

Providers should submit claims for influenza and pneumococcal vaccinations using the UB-92 claim form. Refer to the Claims Submission chapter of this handbook for further information about the UB-92 claim form. When billing for a vaccine, providers should list both the procedure code appropriate for the type of home health skilled nursing visit (initial or subsequent) and the procedure code for the type of vaccine administered. Refer to Appendix 19 of this handbook for a list of procedure codes for home health skilled nursing visits and vaccines.

Home health agencies may administer the influenza and pneumococcal vaccines to recipients who they are currently serving when there is a physician order for the vaccination.

Since the pneumococcal vaccine is not administered on an annual basis, it is important that the recipient's primary care provider be notified when the vaccine is given.

Community Vaccination Clinics

Home health agencies may also submit claims to Wisconsin Medicaid for medically necessary influenza and pneumococcal vaccinations provided at community vaccination clinics. There must be established written protocol, policy, and guidelines that are approved by the agency's medical director.

Providers are required to submit a separate UB-92 claim form for each recipient receiving these vaccines. Wisconsin Medicaid does not accept rosters of recipients who received vaccines. Refer to Appendix 19 of this handbook for a list of procedure codes for vaccines.

Optional Form

Since the pneumococcal vaccine is not administered on an annual basis, it is important that the recipient's primary care provider be notified when the vaccine is given. If the recipient receives the pneumococcal or influenza vaccine in a community clinic, refer to Appendix 27 of this handbook for the Adult Immunization Record, an optional form that the recipient can give to his or her physician.

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Covered Skilled Nursing Services

Intake Evaluations

Federal regulations require home health agencies to have written policies concerning the acceptance of recipients by the agency. When personnel of the agency make an intake evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not reimbursable separately as a skilled nursing visit, since at this point the recipient has not been accepted for care.

If, however, during the course of this intake evaluation visit, the recipient is determined suitable for home health care by the agency and is also provided the first skilled nursing service as ordered by the plan of care (POC), the visit would become the first reimbursable home health skilled nursing visit.

Assessments

Reimbursable Assessments

Assessment of a recipient's condition is always a part of required nursing supervision. However, the assessment of the recipient's condition may be reimbursable as a skilled nursing service when:

- The recipient's medical condition requires a nurse to identify and evaluate the need for possible modification of treatment. This may include when the following indications are present and documented:
 - ✓ Abnormal or fluctuating vital signs.
 - ✓ Weight changes.
 - ✓ Edema.
 - ✓ Symptoms of drug toxicity.
 - ✓ Abnormal or fluctuating lab values.
 - ✓ Respiratory changes on auscultation.

A one-time visit by a registered nurse (RN) may be medically necessary to assess and evaluate the medical condition of the recipient in response to a home health aide, personal care worker (PCW), the recipient or the recipient's family, or another person expressing concern that the recipient's medical condition may have changed. This assessment visit may be covered whether or not the visit results in intervention or a change in the POC. Providers may request an amendment to a prior authorization (PA) to cover this visit.

- The recipient's medical condition requires a nurse to initiate additional medical procedures until the recipient's treatment regimen stabilizes but is not part of an established pattern of care.

A recipient often requires a skilled nursing assessment during the first 30 days following hospital discharge or until the recipient's medical condition and treatment regimen stabilizes.

- There is a likelihood of complications or an acute episode requiring a nurse to identify and evaluate the recipient's need for possible modification of treatment or initiation of additional medical procedures until the recipient's treatment regimen is essentially stabilized.

When a recipient is admitted to home health care for assessment because there is reasonable potential of a complication or further acute episode, the skilled assessment services are covered only for as long as there remains a reasonable potential for such a complication or acute episode. Medical record documentation must support the likelihood of a future complication or acute episode.

Federal regulations require home health agencies to have written policies concerning the acceptance of recipients by the agency.

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Examples of Reimbursable Assessments

The following are examples of reimbursable assessments:

- A recipient with arteriosclerotic heart disease with unstable congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation or adverse affects from prescribed medication. Skilled assessment is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the recipient's treatment regimen is essentially stabilized.
- A recipient has undergone peripheral vascular disease treatment, including a bypass. The incision area is showing signs of potential infection and the recipient has an elevated temperature. Skilled assessment of the perfusion of the legs and the integrity of the incision site is necessary until the signs of potential infection have abated.

Reimbursable Ongoing Assessment Visits

When an assessment visit does not meet the guidelines for medical necessity, it may be reimbursed as an ongoing assessment (Title 19 re-evaluation) visit if all of the following criteria are met:

- The recipient's medical condition is stable (a medical condition is considered stable when the recipient's physical condition is non-acute and without substantial variability at the current time).
- The recipient has not received a covered skilled nursing service (including medication management), covered personal care service, or covered home visit by a physician within the past 62 days.

- A skilled assessment is required to re-evaluate the continuing appropriateness of the POC.

In accordance with federal Medicaid regulations, the visit must be ordered by a physician in order to be covered. In the ongoing assessment visit, the RN is required to do the following:

- Assess the recipient's current medical condition (including systems assessment, environmental assessment, psychosocial assessment, and functional assessment).
- Evaluate the recipient's progress or lack of progress towards meeting established goals.
- Modify the POC as needed.

The ongoing assessment visit is to be used to assess the recipient who is only receiving home health aide services or home health aide and home health therapy services. Persons receiving covered skilled nursing visits must be assessed during those covered visits. Skilled nursing services include the following:

- Private duty nursing provided by an RN or licensed practical nurse (LPN).
- Private duty nursing for ventilator-dependent recipients provided by an RN or LPN.
- Initial or subsequent home health nursing visits.
- Personal care supervisory visits.

Wisconsin Medicaid may reimburse for ongoing skilled nursing assessments and visits provided once every 55 calendar days.

Prior authorization is not required for an ongoing assessment visit. Providers are required to submit claims using the ongoing assessment visit procedure code. Refer to Appendix 19 of this handbook for a complete list of procedure codes.

P Prior authorization is not required for an ongoing assessment visit.

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Examples of Non-Reimbursable Ongoing Assessments

The following are examples of non-reimbursable ongoing assessments:

- A physician orders one skilled nursing visit every two weeks and three PCW visits each week for bathing and washing hair for a recipient whose recovery from a cerebral vascular accident has caused a residual weakness on the left side. The recipient's condition is stable and the recipient has reached the maximum functional independence. There are currently no underlying conditions that would necessitate a skilled assessment, therefore an ongoing assessment visit would not be covered in this situation because a personal care visit is more appropriate.
- A visit that is made specifically for filling out paperwork, such as an Outcome and Assessment Information Set (OASIS), is not covered.

If intermittent catheterization is delegated to an LPN or home health aide by the RN, medical record documentation must support that the LPN or home health aide has been taught the procedure and has demonstrated competence in the procedure.

Tube Insertions and Feedings

Nasogastric, gastrostomy, and jejunostomy tube feeding are covered services. Replacement, stabilization, and suctioning of the tubes are also covered skilled nursing services.

If the feeding of a recipient via gastrostomy or jejunostomy tube is delegated to an LPN, home health aide, or PCW, medical record documentation must support that the caregiver has been instructed in all aspects of tube feeding. This delegation may occur only when deemed appropriate by the supervising RN after assessment of the recipient's medical condition.

Nasopharyngeal and Tracheostomy Suctioning

Nasopharyngeal and tracheostomy suctioning are skilled nursing services and are covered as skilled nursing services if they are required to treat the recipient's medical condition.

Catheters

Insertion and sterile irrigation and replacement of indwelling urinary catheters and care of suprapubic catheters are considered skilled nursing services. When the catheter is necessitated by a permanent or temporary loss of bladder control, medically necessary skilled nursing services that are provided at a frequency appropriate to the type of catheter in use are reimbursable.

When complications are absent, Foley catheters generally require skilled service once every 30 days and silicone catheters generally require skilled service once every 60-90 days. More frequent care may be reimbursed if documentation supports the medical necessity. This frequency of service is considered reasonable and medically necessary. In some instances, there are complications that require more frequent skilled services related to the catheter.

If intermittent catheterization is delegated to an LPN or home health aide by the RN, medical record documentation must support that the LPN or home health aide has been taught the procedure and has demonstrated competence in the procedure.

Wound Care

Wound care relates to the direct, hands-on skilled nursing care provided to recipients with wounds, including any necessary dressing changes on those wounds.

Wound care, including but not limited to ulcers, burns, pressure sores, open surgical sites, fistulas, and tube sites, is a skilled nursing service when the skills of a licensed nurse are needed to safely and effectively care for the wound. For skilled nursing care to be reasonable and necessary to treat a wound, the grade, size, depth, nature of drainage (color, odor, consistency, and quantity), condition, and appearance of the surrounding skin of the wound must be documented in the POC. This allows an assessment of the need for skilled nursing to be made.

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The POC must contain the specific instructions for the wound treatment. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications) of wounds with the following characteristics, the skills of a licensed nurse may be reasonable and necessary:

- Open wounds that are draining purulent exudate or that have a foul odor present and/or for which the recipient is receiving antibiotic therapy.
- Wounds with a drain or T-tube that requires interval position changes.
- Wounds that require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze.
- Recently debrided ulcers.
- Pressure sores (decubitus ulcers) that present the following characteristics:
 - ✓ Partial tissue loss with signs of infection, such as foul odor or purulent drainage.
 - ✓ Full thickness tissue loss that involves exposure of fat or invasion of other tissue, such as muscle or bone.
- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed.
- Open wounds or widespread skin complications following radiation therapy or that result from immune deficiencies or vascular insufficiencies.
- Post-operative wounds where there are complications, such as infection or allergic reaction, or there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes).
- Third degree burns and second degree burns, where the size of the burn or presence of complications causes skilled nursing care to be needed.
- Other open or complex wounds that require treatment that can be safely and effectively provided only by a licensed nurse.

For skilled nursing services to continue, there must be on-going medical record documentation of the grade, size, depth, nature of drainage, and condition of the wound and appearance of surrounding skin.

Skilled nursing care is ordinarily not required for wounds or ulcers that show redness, edema and induration, at times with epidermal blistering or desquamation. Wounds that only require an antibacterial ointment, nonsterile covering, occlusive covering, opsite or duoderm, and wounds with minimal serous or serosanguinous drainage also do not require skilled nursing care.

However, while the initial care for a wound might not require the services of a skilled nurse, the wound may still require skilled monitoring and assessment for signs and symptoms of infection or complication.

The POC must contain the specific instructions for the wound treatment.

Ostomy Care

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching of ostomy care is reimbursable during the time that a skilled assessment or an other covered skilled nursing care is required.

Venipuncture

Reimbursable Venipunctures

Venipuncture is a skilled nursing service when the collection of the specimen is necessary to the diagnosis and treatment of the recipient's medical condition and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment. The frequency of visits for venipuncture must be reasonable within accepted standards of medical practice for

Teaching and training activities that require skilled nursing personnel to teach a recipient, the recipient's family, or unpaid caregivers how to manage the treatment regimen would constitute skilled nursing services only when provided to a recipient in conjunction with other reimbursable skilled nursing services.

treatment of the medical condition. Venipuncture is reasonable and necessary when the following occurs:

- The treatment is recognized as being reasonable and medically necessary to the treatment of the medical condition. The physician order for the venipuncture should clarify the need for the test when it is not diagnosis/illness specific.
- The frequency of the testing is consistent with accepted standards of medical practice for continued monitoring and assessment of a diagnosis, medical problem, or treatment regimen. Even when the laboratory results are consistently stable, periodic venipunctures may be reasonable and necessary because of the nature of the treatment.

Reimbursable Venipuncture for Prothrombin

Venipuncture may be reimbursable when the following is true:

- Documentation shows that the dosage is being adjusted and ongoing monitoring is ordered by the physician.
- The results are stable within non-therapeutic ranges. There must be documentation of other factors that would indicate why continued monitoring is reasonable and medically necessary.
- The results are stable within the therapeutic ranges. Monthly monitoring may be reasonable and necessary.

Examples of Reasonable and Necessary Venipunctures

The following are examples of reasonable and necessary venipunctures:

- Many medications may cause side effects, such as leukopenia and agranulocytosis, and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every three months) when the results are stable and the recipient is asymptomatic.

- In monitoring phenytoin (e.g., Dilantin®) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight. It is therefore appropriate to monitor the level on a routine basis (every three months) when the results are stable and the recipient is asymptomatic.
- A recipient with coronary artery disease was hospitalized with atrial fibrillation and was subsequently discharged to the home health agency with orders for anticoagulation therapy. Monthly venipunctures as indicated are necessary to report prothrombin (protime) levels to the physician.

Teaching and Training Activities

Reimbursable Teaching and Training Activities

Teaching and training activities that require skilled nursing personnel to teach a recipient, the recipient's family, or unpaid caregivers how to manage the treatment regimen would constitute skilled nursing services only when provided to a recipient in conjunction with other reimbursable skilled nursing services.

When it becomes apparent after a reasonable period of time that the recipient, family, or caregiver is unwilling or unable to learn or be trained, further teaching and training ceases to be reasonable and medically necessary. The reason that the recipient, family, or caregiver is unwilling or unable to be trained should be documented in the medical record.

Examples of Reimbursable Teaching and Training Activities

The following are examples of reimbursable teaching and training activities:

- A physician has ordered skilled nursing services for a man who was hospitalized for a broken hip and has now been

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discharged to home. While hospitalized, the recipient was newly diagnosed with diabetes. Skilled nursing care is ordered to closely monitor blood glucose levels until the levels stabilize and to assess understanding of and compliance with a diabetic diet. In this case, teaching of self-injection and management of insulin, signs and symptoms of insulin shock and actions to take in emergencies is reasonable and necessary to the treatment of the medical condition, since the recipient is receiving skilled care and cannot reasonably be expected to go to his physician for the instruction.

- A recipient with arteriosclerotic heart disease and congestive heart failure requires close observation by a nurse for signs of decompensation or adverse affects resulting from newly prescribed medication. When visiting the recipient to assess his or her medical condition, teaching about the medication regimen is appropriate. (Under Wisconsin pharmacy law and Wisconsin Medicaid regulations, pharmacists are required to instruct the person picking up a prescription about the medication, including instructions for administration and signs of adverse reactions. In most cases, the person obtaining the prescription may also obtain this information over the telephone.)

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Covered Home Health Aide Services

There are three components to the services home health aides may provide in the home:

- Delegated nursing acts.
- Activity of daily living (ADL) tasks.
- Household tasks.

To qualify for home health aide services, each visit must include at least one delegated nursing act that a personal care worker (PCW) cannot safely perform as determined by the delegating registered nurse (RN). Refer to personal care publications for further information about services that may be performed by PCWs.

Delegated Nursing Acts

Delegated nursing acts are those medically necessary tasks that require some special medical knowledge or skill. Delegated nursing acts are usually reimbursed for minor children. Delegated nursing acts that may be safely delegated by an RN may be reimbursable home health aide services. Delegated nursing acts include, but are not limited to, the following:

- Medication administration.
- Skin care.
- Dressing changes.
- Assistance with activities directly supportive of skilled therapy services.
- Vital signs.
- Glucometer readings.
- Complex transfers.
- Complex repositioning.
- Complex feeding.
- Donning or doffing of a prosthesis or orthosis.
- Active seizure intervention.

Medication Administration

“Administer” is defined in the Pharmacy Examining Board Act, Chapter 450.01(1), Wis. Stats., as the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

Medication administration may be covered for an adult recipient when the recipient is unable to self-administer and there is no willing and able caregiver to administer the medication.

Parents typically administer medications to their minor children. However, medication administration may be reimbursed for minor children when the parents are unable to administer the medication. This includes times when parents are not allowed to leave work to administer medications and no other arrangements can be made.

General Agency Requirements Applicable to All Medication Administration by Home Health Aides

All home health agencies providing administration of a medication by a home health aide must meet the following conditions:

- The agency has policies and procedures designed to provide safe and accurate administration of medication. These policies must be followed by personnel assigned to administer medications (42 CFR s. 484.14[e]). This must include the required documentation of the name of the medication, the dose, the route of administration, the time of administration, and the identification of the person administering the medication.
- There is a written delegation of this nursing act (medication administration) by the RN as specified in HFS 133.17(3), Wis. Admin. Code.

Delegated nursing acts are those medically necessary tasks that require some special medical knowledge or skill.

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- There is documentation that gives evidence of the educational preparation of the caregiver who administers medications as stated in HFS 133.06(4)(b), Wis. Admin. Code.
- There is immediate and accessible supervisory support available to the caregiver administering medications as directed by HFS 133.18(2), Wis. Admin. Code.
- Recipients must be informed, prior to delivery of service, that their medications will be administered by unlicensed personnel as stated in HFS 133.08(2)(d), Wis. Admin. Code, and 42 CFR s. 484.10(c)(1).
- Supervision and direction of the delegated nursing act meets the requirements of ch. N 6.03(3), Wis. Admin. Code, which states that in the supervision and direction of delegated nursing acts, an RN shall do the following:
 - ✓ Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.
 - ✓ Provide direction and assistance to those supervised.
 - ✓ Observe and monitor the activities of those supervised.
 - ✓ Evaluate the effectiveness of acts performed under supervision.

Administration of Preselected Medication

A home health aide may administer medications to any recipient, regardless of age or functional capacity, when both of the following conditions are met:

- The medication is preselected by a nurse, pharmacist, recipient, or designated family member.
- All agency requirements are met.

Administration of Medication That Is Not Preselected

Administration of medications by home health aides may include selection of the medication and selection of the dose, along with direct application of the medication.

The act of administration of medication that has not been preselected may be provided by home health aides only when both of the following conditions are met and documented in the provider’s records:

- When medication has not been preselected, there is documented evidence that the home health aide has been trained in the actions, uses, effects, adverse reactions, and toxic effects of all medications administered. Additionally, the home health aide must be trained relative to appropriate responses to adverse reactions to any medication administered. The delegating RN must verify the training by doing at least one return demonstration with each home health aide administering medication to a specific recipient as directed by HFS 133.06(4)(c), Wis. Admin. Code.
- All agency requirements are met.

Skin Care

Skin care may be a delegated nursing act and medically necessary when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Typically, a legend drug is a medication not sold over-the-counter. Pro re nata or prophylactic skin care is an ADL task, not a delegated nursing act.

Administration of medications by home health aides may include selection of the medication and selection of the dose, along with direct application of the medication.

Complex transfers may be medically necessary when the recipient has no volitional movement or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

Dressing Changes

Some dressing changes may not require the skills of a licensed nurse and may be safely performed by a home health aide. Wounds or ulcers that show redness, edema, or induration — at times with epidural blistering or desquamation — do not ordinarily require skilled nursing care. Dressing changes may be medically necessary when the physician orders them for the treatment of a wound or sore and no primary caregiver is willing or able to provide the care.

Assistance with Activities That Are Directly Supportive of Skilled Therapy Services

Assistance with activities that directly support skilled therapy services include those activities that do not require the skills of a therapy provider to be safely and effectively performed. Activities may include routine maintenance exercises, e.g., range of motion exercises and repetitive speech routines. In order to be medically necessary, the activities must be ordered in conjunction with an active home health therapy program or as the direct result of a therapy evaluation completed and signed by a therapy provider within the past six months.

Vital Signs

Taking vital signs may include, but are not limited to taking the following readings from the recipient:

- Temperature.
- Blood pressure.
- Pulse.
- Pulse oximetry readings.
- Respiratory rate.

The recipient's vital signs are to be reported to the supervising nurse whenever they are outside the parameters established for the recipient by the physician. Taking vital signs may be medically necessary when the recipient's medical history supports the need for ongoing monitoring for early detection of an exacerbation and the physician establishes parameters at which point a change in treatment may be required.

Glucometer Readings

Taking glucometer readings and reporting them to the supervising nurse whenever the readings are outside the parameters established for the recipient by the physician may be medically necessary when the recipient's medical history supports the need for ongoing monitoring for early detection of readings outside the established parameters. Glucometer readings related to the noncompliance of a competent adult do not justify glucometer tests as medically necessary tasks.

Complex Transfers

Complex transfers are transfers that require the use of mechanical devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly, or when a complex transfer technique is used as part of a home health therapy program.

The following transfer techniques are part of the suggested personal care curriculum and *do not qualify as complex transfers*:

- Standing-pivot.
- Sliding board.
- Gait belts.

Complex transfers may be medically necessary when the recipient has no volitional movement or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

Complex Repositioning

Complex repositioning is positioning to reduce spasticity or to decrease pressure and/or shear forces that can lead to decubitus ulcer formation (i.e., Bolsters/Side-Lyers). Complex repositioning may be medically necessary when the recipient has a demonstrated problem with frequent skin breakdown.

Complex Feeding

Complex feeding may be a delegated nursing act and medically necessary when there is a potential for aspiration and the physician's orders indicate special feeding precautions or techniques must be utilized to effect safe feeding.

Feeding via a gastrostomy tube may be a delegated nursing act when delegated by the RN after assessment of the recipient's medical condition and the home health aide's training.

Donning and Doffing of a Prosthesis or an Orthosis

Donning or doffing of a prosthesis or orthosis may be a delegated nursing act and medically necessary when part of a serial splinting program or when the recipient has a demonstrated problem with frequent skin breakdown that must be closely monitored.

Active Seizure Intervention

Active seizure intervention, including safety measures, reporting seizures, and administration of medication at the time of the active seizure, may be a delegated nursing act. Active seizure intervention may be medically necessary when the recipient has had active seizures requiring active intervention within the past 62 days. Active seizure intervention does not include administration of routine anti-seizure medication. When observation for seizures is the only service performed, it is not a Medicaid reimbursed service.

Activity of Daily Living Tasks

Assistance with the recipient's ADLs as listed in HFS 107.11(2)(b)2, Wis. Admin. Code, is considered a home health aide service only when provided in conjunction with a delegated nursing act that cannot be safely delegated to a PCW as determined and documented by the delegating RN. Activity of daily living tasks are not generally provided to preschool children but may be covered when the tasks require special skills to assure safety or are provided incidental to a delegated nursing act.

Household Tasks

When a home health aide visits a recipient to provide a delegated nursing act, the home health aide may also perform some household tasks. Provision of household tasks must be incidental to delegated nursing acts and personal care tasks, and must not be the primary reason for the home health aide visit.

Household tasks are typically provided by parents for their minor children. Most household tasks provided to minor children are not covered. Incidental household tasks may be reimbursed only when the tasks are incidental to covered delegated nursing acts or covered ADL tasks.

When a home health aide visits a recipient to provide a delegated nursing act, the home health aide may also perform some household tasks.

Plan of Care

Home health services must be provided according to the recipient's written, signed, and dated plan of care (POC) as defined in HFS 105.16(1), Wis. Admin. Code.

Plan of Care Documentation Methods

When completing and submitting the POC, home health providers may use either the Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096, or the recipient's POC in another format that contains *all* of the components requested in the completion instructions of the PA/HCA.

When completed according to the completion instructions, the PA/HCA contains the information Wisconsin Medicaid requires to adjudicate a provider's PA request for home care services.

Wisconsin Medicaid requires complete and accurate information to adjudicate PA requests submitted for home care services. Incomplete PA requests will be returned to the provider.

Submitting Another Format for the Recipient's Plan of Care

Providers who choose to submit the recipient's POC in another format are required to include all of the components requested in the Prior Authorization/Home Care Attachment Completion Instructions, HCF 11096A. Prior authorization requests received without the requested information will be returned to the provider.

Providers choosing this option should note that the nurse and physician who sign and date the POC are required to attest to the respective Wisconsin Medicaid certification statements in Section VI of the PA/HCA Completion Instructions.

To speed processing and reduce the number of returned PA requests, providers are strongly encouraged to verify that all requested information is included with the PA request when choosing to submit a version of the POC other than the PA/HCA.

Obtaining Plan of Care Forms

The completion instructions and PA/HCA are located in Appendices 3 and 4 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Developing the Plan of Care

Development of the POC should be based on the orders of a physician, a visit to the recipient's residence by either a registered nurse or therapist, as appropriate, and in consultation with the physician, the recipient, or as appropriate, the recipient's legal representative, the recipient's family, and other members of the household.

When developing the POC, the provider should also assess the recipient's social and physical environment, including the following:

- Family involvement.
- Living conditions.
- The recipient's level of functioning.
- Any pertinent cultural factors.

Licensed practical nurses may not develop the POC.

Recipient's Other Household Members

Wisconsin Medicaid encourages other members of a recipient's household to participate in providing care to the recipient. However, this participation is not a condition of coverage.

Development of the POC should be based on the orders of a physician, a visit to the recipient's residence by either a registered nurse or therapist, as appropriate, and in consultation with the physician, the recipient, or as appropriate, the recipient's legal representative, the recipient's family, and other members of the household.

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With the permission of the recipient or the recipient's legal representative, the provider should ask members of the household about the extent they are able and willing to provide medically necessary covered services for the recipient. If household members are not willing or able to provide care, the nurse should document the reasons why in the recipient's medical record. A Community Options Program assessment or narrative reflecting possible informal support systems meets this requirement.

When medically necessary covered services that are normally furnished by the provider are instead provided by willing and able household members, these services cannot be billed to Wisconsin Medicaid.

Physician's Orders and Signature

All home health services require a physician's order or prescription. Wisconsin Medicaid will not reimburse for services provided *before* a physician's order or prescription is obtained. The order or prescription shall be in writing or given verbally and later be reduced to writing by the nurse. All orders or prescriptions must be reviewed, signed, and dated by the prescribing physician as stated in HFS 107.02(2m), Wis. Admin. Code.

The initial POC containing the physician's orders must be reviewed, signed, and dated by the physician within 20 working days following the recipient's start of care. All subsequent POC must be reviewed, signed, and dated by the physician *prior to* the beginning of the new certification period.

Start of Care

The start of care date is the date of the recipient's first billable home care visit. This date remains the same on all subsequent POC until the recipient is discharged from uninterrupted service.

Certification Period

Each certification period may last no longer than 62 days. The 62-day period corresponds with the certification period dates in Element 4 of the PA/HCA and includes both the "From" date and the "To" date. The POC expires at the end of the 62-day certification period. (Medicare certified agencies should use the timeframe of up to, but not more than, *60 days* later.)

Wisconsin Medicaid requires that all components of the POC be reviewed by a physician at least every 62 days as stated in HFS 105.16(1), Wis. Admin. Code. If multiple physicians order services, orders are combined on one POC and reviewed, signed, and dated by the primary physician at least every 62 days. The home health agency has the responsibility to sign and confirm the date that the information on the POC was reviewed with the physician, to verify that the POC is complete, and to keep a current and complete POC on file.

Once the physician reviews, signs, and dates the POC, it serves as the physician's orders for the length of the certification period.

The physician must review, sign, and date all subsequent POC *prior to* the beginning certification date on the POC. Otherwise, the agency is providing services without orders, and such services will not be reimbursed by Wisconsin Medicaid.

Verbal Orders

At times, the physician may give an order verbally.

Verbal Orders for Initial Certification

To facilitate immediate access to home care services, Wisconsin Medicaid allows home health agencies to be reimbursed for services provided under verbal orders. The agency is required to reduce the verbal orders to writing and transmit the orders to the physician immediately and obtain the physician's signature and date on those orders within 20 working days.

Wisconsin Medicaid requires that all components of the POC be reviewed by a physician at least every 62 days as stated in HFS 105.16(1), Wis. Admin. Code.

Verbal Orders for Subsequent Certification

Once care has started, *verbal orders may not be obtained for subsequent certification periods*. For ongoing cases, the physician must review, sign, and date renewed or (as necessary) revised orders before the end of the certification period for the agency to continue to be reimbursed without interruption after starting care of the recipient.

Verbal Orders Within Any Certification Period

An *urgent* situation may prompt the physician to issue verbal orders. Such verbal orders *during* the authorized certification period are the direct result of changes in the patient's condition necessitating an immediate modification to the POC. For example, the recipient's adverse reaction to a currently prescribed medication or treatment may result in a physician verbally ordering a change to the recipient's treatment or medication.

When verbal orders are necessary within a certification period, the agency must document the orders, reduce them to writing, and sign and date them. The agency has 10 days from the date the physician gave the orders to obtain the physician's signature and date on those orders.

When verbal orders are necessary within a certification period, the agency must document the orders, reduce them to writing, and sign and date them.

- Activities permitted.
- Nutritional requirements.
- Medications and treatments.
- Any safety measures to protect against injury.
- Instructions for timely discharge or referral.
- Home health therapy services that include specific procedures and modalities to be used and the amount, frequency, and duration.
- A dated physician's signature signifying that the physician has reviewed the POC.
- Methods for delivering needed care, and an indication of which, if any, professional disciplines are responsible for delivering the care.
- An identification of all other parties providing care to the recipient and the responsibilities of each party for that care.
- Measurable time-specific goals.
- Nursing and emergency interventions.
- Parameters for all pro re nata orders.
- Other items as appropriate to the recipient's case.
- A plan for medical emergency.
- A plan to move the recipient to safety in the event of a condition that threatens the recipient's immediate environment.

Plans of care for ventilator-dependent recipients must also include the following elements:

- Ventilator settings and parameters.
- Procedures to follow in the event of accidental extubation.

Medically necessary cares as ordered by a physician are to include cares that may be claimed by professional providers *and* cares routinely provided by the family and other volunteer caregivers.

In addition to the elements required on the POC by HFS 101.03(124m), Wis. Admin. Code, agencies should include a brief clinical history and summary of the recipient's condition to expedite the PA request. This additional information may decrease the frequency of returned PA requests.

Plan of Care Requirements

As specified in and supported by HFS 101.03(124m), 105.16(10)(e), 106.02(9), and 107.02(2)(f) Wis. Admin. Code, the POC must include all of the following information:

- All pertinent diagnoses, including cognitive status.
- Type of services and equipment required.
- Frequency of visits.
- Prognosis.
- Rehabilitation potential.
- Functional capabilities and limitations, including cognitive status, dietary needs, and allergies.

For samples of POC documented on the PA/HCA, providers may refer to Appendices 5 and 6 of this handbook.

Medical Necessity and the Plan of Care

The recipient's health status and medical need, as reflected in the POC, provide the basis for determinations as to whether services provided are reasonable and medically necessary.

Each provider is responsible, along with the physician, for the contents of the POC relating to the medical necessity of care, accuracy of all information submitted and relevance of the POC to the recipient's current medical condition. Providers are required to do the following:

- Promptly notify the recipient's physician of any change in the recipient's condition that suggests a need to modify the POC.
- Implement any changes that were made to the POC.

Providers are required to include a complete, detailed, and accurate description of the recipient's medical condition and needs in the POC. The POC should be developed and reviewed concurrently and in support of other health care providers providing services to the recipient in the home.

Changes to the Plan of Care

When the recipient's medical needs change, the provider is required to notify the physician so that the physician may order a change to the POC to reflect the recipient's current medical needs.

It is illegal to add or change orders on a POC after it has been signed by a physician. To add or change orders, providers must have on file a signed and dated copy of the new physician orders to the POC. These changes must be incorporated into the next POC, prior to it being signed by the physician.

Wisconsin Medicaid will *not* accept correction fluid or correction tape on a POC. When correcting errors on a POC before it is signed, a nurse should cross out the error with a single line and place his or her initials and date next to the correction. Wisconsin Medicaid will return a POC with other methods of correction to the provider.

When the recipient's medical needs change, the provider is required to notify the physician so that the physician may order a change to the POC to reflect the recipient's current medical needs.

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Prior Authorization

Prior authorization (PA) is approval of coverage of services by Wisconsin Medicaid before the provision of the services. Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved Prior Authorization Request Form (PA/RF), HCF 11018. If the provider delivers a service either before the grant date or after the expiration date of an approved PA, or provides a service that requires PA without obtaining PA, the provider is responsible for the cost of the service. In these situations, providers may not collect payment from the recipient.

When requesting PA for services, providers should note the following:

- Chapter HFS 107.02(3), Wis. Admin. Code, provides Wisconsin Medicaid with the authority to require PA for covered services. It also provides procedures for PA documentation and departmental review criteria used to authorize coverage and reimbursement.
- A request for PA does not guarantee approval.
- Prior authorization does not guarantee payment. To receive Medicaid reimbursement, provider and recipient eligibility on the date of service (DOS) as well as all other Medicaid requirements must be met.
- Providers are required to submit PA requests *separately* from their certification materials.

For more information about general PA policies, obtaining PA forms and attachments, and submitting PA requests, refer to the Prior Authorization section of the All-Provider Handbook.

Services Requiring Prior Authorization

Wisconsin Medicaid requires PA for the following services provided by home health agencies:

- All home health skilled nursing, medication management, home health aide, and home health therapy visits by all providers after the first 30 visits in a calendar year.
- Visits made by *all* providers from the home health agency accumulate toward the 30-visit threshold. After the first 30 visits, if one provider in a shared case requires PA, all providers on that case are required to have PA.
- All private duty nursing (PDN) services as stated in HFS 107.12(2)(a), Wis. Admin. Code.
- All home health and personal care worker (PCW) services that are provided in conjunction with PDN services.
- All home health services provided by nurses in independent practice (NIP).

Wisconsin Medicaid does not reimburse these services if they are provided:

- Without an approved PA.
- Before the grant date on the PA/RF.
- After the expiration date on the PA/RF.

Prior authorization does not guarantee reimbursement. Provider eligibility, recipient eligibility, and medical status on the DOS, as well as all other Medicaid requirements, must be met before the claim is paid.

Prior authorization does not guarantee reimbursement.

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Required Documentation for Prior Authorization Requests

Providers are required to submit a PA/RF for all home health services requiring PA.

Refer to Appendix 17 of this handbook for a list of all attachments that must be submitted with the PA/RF for each type of service.

Two Caregivers Providing Care for a Recipient at the Same Time

When it is medically necessary and PA has been obtained, Wisconsin Medicaid may reimburse for a PCW to assist a registered nurse (RN), licensed practical nurse (LPN), home health aide, or another PCW. If two providers are caring for a recipient simultaneously, one provider must be a PCW. The situations in which a PCW may assist are:

- Periodic changing of the entire tracheostomy tube.
- Periodic transfer or repositioning of a recipient when a two-person transfer is required to assure safety because all other transfer devices have failed.

The provider is required to document on the plan of care (POC) the reason that two caregivers are required.

Home Health Skilled Nursing, Medication Management, Home Health Aide, and Home Health Therapy Visits

A recipient may receive a total of 30 visits, including home health skilled nursing services, medication management services, home health aide services, and home health therapy services, per calendar year before PA is required by Wisconsin Medicaid. Prior authorization is required when the total of any combination of these services per recipient exceeds 30 visits, regardless of the provider or service.

For example, if a recipient received ten home health aide initial visits, five home health aide subsequent visits, five home health skilled nursing initial visits and 10 physical therapy visits, for a total of 30 visits, PA is required before any further services will be reimbursed by Wisconsin Medicaid during the same calendar year.

If the recipient has received home health services from another provider during the calendar year, those visits are also counted toward the 30-visit threshold.

Although providers are permitted to provide 30 visits without PA in a new calendar year, providers are encouraged to request PA immediately upon completion of the POC so that reimbursement is not jeopardized.

Ongoing Assessments

Ongoing assessments do not require PA and do not count toward the 30-visit threshold. Refer to the Covered Skilled Nursing Services chapter of this handbook for further information on ongoing assessments.

Medication Management

Medication management visits require PA and count toward the 30-visit threshold. Refer to the Medication Management chapter of this handbook for further information on medication management visits.

Shared Cases

For each calendar day, there can only be one initial visit for any given procedure code, regardless of the number of providers providing services to the recipient on that day. Providers with shared cases should coordinate with each other to determine which agency will provide the initial visit. This information must be indicated on the PA/RF. Additional visits for the same procedure code on the same calendar day are classified as subsequent visits.

A recipient may receive a total of 30 visits, including home health skilled nursing services, medication management services, home health aide services, and home health therapy services, per calendar year before PA is required by Wisconsin Medicaid.

The total number of visits requested per week on the PA/RF must exactly match the number of weekly visits indicated on the POC.

Providers should verify that requests for PA specify the appropriate number and type of visits to assure consistent recipient care and proper reimbursement. For this reason, coordination between providers of shared cases is strongly encouraged.

Refer to Appendix 5 of this handbook for a sample Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096, of a shared case.

Continuous Visits

When a home health aide initial or subsequent visit in excess of four continuous hours is medically necessary and providers believe reimbursement for one visit is not sufficient, providers may request PA to enable them to bill for multiple home health aide visits. The provider is required to indicate the following on the PA/RF: “Authorization requested to bill for (number of) subsequent HH aide visits due to (number of) continuous hours of care.”

Documentation submitted must support the medical necessity of the continuous visits.

In determining the number of continuous home health aide visits PA will be granted for, consideration will be given to the recipient’s needs and special circumstances.

Pro Re Nata Visits

Providers may request pro re nata (PRN) or “as needed” visits only when service is likely to vary due to changes in the recipient’s need for services. If the use of PRN visits is anticipated, the specific number of PRN visits must be included in the POC and requested by procedure code per week or month of service on the PA/RF. Pro re nata visits must be added to the regularly scheduled number of visits requested for a particular procedure code. The reason for the PRN visits must be explained based on recipient-centered parameters.

Refer to Appendix 12 of this handbook for an example PA/RF requesting PRN visits.

Documentation Requirements for Home Health Skilled Nursing and Home Health Aide Services

Providers requesting PA for home health skilled nursing and home health aide services are required to include the PA/RF and either the PA/HCA or the recipient’s POC in another format that contains *all* of the components requested in the Prior Authorization/Home Care Attachment Completion Instructions, HCF 11096A. Refer to the Plan of Care chapter of this handbook for further information.

Providers are required to indicate the expected number of initial and subsequent visits per day, the number of days per week, and the number of weeks or months of service per service type on the PA/RF. The total number of visits requested per week on the PA/RF must match the number of weekly visits indicated on the POC. Services by another provider, whether another home health agency, NIP, or volunteer, must be indicated on the POC.

Documentation Requirements for Medication Management Visits

Providers requesting PA for medication management services are required to include the PA/RF and either the PA/HCA or the recipient’s POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions. Refer to the Plan of Care chapter of this handbook for further information.

Providers are required to indicate the expected number of visits per week and the number of weeks or months of service on the PA/RF. The total number of visits requested per week on the PA/RF must exactly match the number of weekly visits indicated on the POC. Services by another provider, whether another home health agency, NIP, or volunteer, must be indicated on the POC.

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Documentation Requirements for Home Health Therapy Services

Providers requesting PA for home health therapy services are required to include the following with the PA/RF:

- The Prior Authorization/Home Health Therapy Attachment (PA/HHTA), HCF 11044.
- The therapy POC.
- The therapy evaluation.
- The Individualized Family Service Plan (for children under three years of age enrolled in the Birth to 3 Program).
- The Individualized Education Plan (IEP) (for school-age children between three and 21 years of age).

Providers are required to indicate the expected number of occupational therapy (OT) visits, physical therapy (PT) visits, and speech and language pathology (SLP) visits per day, the number of days per week, and the number of weeks or months of service per discipline on the PA/RF. The total number of visits requested must exactly match the number of visits indicated on the therapy evaluation and/or the POC.

Providers requesting PA both for home health therapy services and other home health services are only required to submit a single PA/RF for all services.

Refer to Appendix 9 of this handbook for a sample PA/HHTA.

Required Prior Authorization Request Information

Prior authorization requests for home health therapy services must contain the following information, or the request will be returned to the provider:

- Reason for the referral.
- Diagnoses, including dates of onset.
- Character of the illness — acute, subacute, or chronic.
- Previous therapy — dates, frequency, amount, and types.

- Evaluations with respect to age, problems to be treated, and potential for achieving stated goals.
- Re-evaluations appropriate to progress.
- Rehabilitation potential — history including previous level of functioning, plan for discharge (i.e., from therapy, from group home to apartment), plans for maintenance, recipient's motivation and cooperation with home health therapy plan, and potential for meeting realistic goals pertaining to functional status.
- Report of home health therapy treatment progress in specific objective and measurable terms.
- Documentation regarding carryover or follow-through by the recipient and/or care giver.

Home Health Therapy Services for School-Age Children

If home health therapy is being requested for a school-age child (between ages 3 and 21 years old), an IEP must be submitted with the PA/RF. If the child is not receiving therapy services according to an IEP, documentation regarding the reasons for the absence of an IEP must be submitted in the PA request. The date of the IEP must be no earlier than 12 months prior to its receipt by Wisconsin Medicaid.

Cotreatment

If two providers request cotreatment for one recipient, each provider is required to complete a separate PA request and submit them together. In addition to completion of PA requirements, the following information must also be included:

- A specific request for cotreatment.
- Identification of the other provider and therapy discipline.
- Documentation verifying the following:
 - ✓ Individual treatment from a single PT, OT, or SLP provider does not provide maximum benefit to the recipient.
 - ✓ Two different therapy disciplines are required to *simultaneously* treat the recipient.

Providers requesting PA both for home health therapy services and other home health services are only required to submit a single PA/RF for all services.

Private Duty Nursing Services

Prior authorization is required for all PDN services before the services may be provided. When submitting a PA request for PDN, the scheduled number of hours requested should reflect the daily care needs of the recipient. The following should be considered when requesting PDN hours:

- Type of medically necessary skilled service needed.
- Stability and predictability of the recipient's clinical course.
- Availability of family/other caregivers.

The physician's orders for PDN should be written in hours per day and days per week.

Hours of Private Duty Nursing for Children

To determine the hours of PDN care for children, providers should consider the extent to which the family and/or other unpaid caregivers are capable of providing medical cares.

Approval of PDN for 24 hours per day may be considered for children in the following circumstances:

- For short-term care after institutional discharge or after in-home exacerbations with significant medical changes, allowing time to teach the family or caregivers and to stabilize the child and develop routine care techniques.
- For short-term care if a single parent or caregiver is hospitalized or if one family member or caregiver is hospitalized and the other is not capable of providing care. Private duty nursing for 24 hours per day may fill the gap until other caregivers can be taught cares, or until the usual family member or caregiver can resume them.

- If the family or caregivers are not *capable* of providing *any* needed cares.

Private duty nursing may be approved for family member or caregiver work time. For example, if the family member or caregiver works outside the home, a reasonable number of PDN hours may be approved to allow for the family member or caregiver's absence from cares for work and commuting to and from work.

If overnight PDN is medically necessary, PDN may be approved for family or caregivers' sleep time. Private duty nursing may be approved for the night shift so the family or caregivers can sleep. Sleep time may be approved during the day if the family member or caregiver works during the night.

Private duty nursing may be approved for medically necessary services if the family needs time to perform family or other similar *responsibilities* of the family or caregivers such as grocery shopping, medical appointments, or picking up medical supplies.

Private duty nursing may be approved for the child's school hours when it is medically necessary for a nurse to accompany the child to school. In many cases, the child meets Wisconsin Medicaid's eligibility criteria for PDN, but is cared for at school by nurses' aides or laypersons, with a school RN available as needed.

When determining the number of PDN hours that will be approved, the following elements will be considered:

- The child's school time.
- The family or caregivers' work schedule
- Any other pertinent information.

To determine the hours of PDN care for children, providers should consider the extent to which the family and/or other unpaid caregivers are capable of providing medical cares.

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Limits on Authorized Services

Authorization is limited to 12 hours in each 24-hour period and 60 hours in a calendar week for any one nurse. These limitations include all services for all recipients who are receiving Medicaid-covered services from the nurse. Wisconsin Medicaid will not approve a PA request for two consecutive 12-hour periods for any one nurse.

A 24-hour period should not be confused with a calendar day. For the purposes of Wisconsin Medicaid PDN services:

- Each calendar day is a 24-hour period that begins at midnight and ends at midnight.
- A calendar week begins with Sunday, ends with Saturday, and consists of seven consecutive calendar days.

Pro Re Nata Hours

Pro re nata, or “as needed,” hours may be requested when there is a reason to expect a deviation in the number of scheduled hours needed due to a change in the recipient’s needs. Pro re nata hours must be medically necessary and the physician’s orders on the POC must specify the number and purpose of the PRN hours requested.

When the provider cannot determine whether an RN or LPN will provide PRN services, the provider may request approval for both by entering both procedure codes on one line of the PA/RF. Separate the procedure codes by a slash. Include a statement that the total number of hours of care does not exceed the total number of hours on the POC.

If after using all the PRN hours granted it is found that additional hours are needed, providers may request an amendment to the PA for more PRN hours. The amendment must include documentation stating the dates all previously granted PRN hours were used and the activities performed during each PRN hour.

Flexible Use of Weekly Hours

Flexible hours allow PDN recipients and their families to use authorized hours of care over an extended period of time. Hours may be used in varying amounts over the approved period of time to meet the needs of the recipient and his or her family. Flexible hours might be used in situations in which a primary caregiver is unable to provide as many hours of care as usual due to an acute illness. Even though flexible use of hours may be approved, the hours must still be medically necessary. Any PDN hours used over those hours approved in the flexibility period are not reimbursable by Wisconsin Medicaid.

Flexibility of hours can be requested to be used in week-long blocks of time. The most common blocks of time are periods of 1, 2, 4, 6, 8, and 9 weeks. Providers should develop a record-keeping system to keep track of the hours of care used. This will help to prevent providers from exceeding the number of hours approved in the period in which flexibility has been authorized.

One suggestion for tracking use of hours is to use the certification period in Element 4 of the PA/HCA.

Any time flexibility is requested, the date that each flexibility period starts must be clearly specified in the POC (Element 15 of the PA/HCA).

Requesting Flexible Use of Hours

To request flexibility in the use of PDN hours, recipients and their families should discuss with the nurse and physician the hours of medically necessary care they require and the time period in which flexibility will be used.

For example, if it is determined that up to 16 hours per day for seven days per week for a total of 112 hours per week of PDN services

Flexibility of hours can be requested to be used in week-long blocks of time.

are required and the hours will be used flexibly over an eight-week period, the request would read as follows:

Private duty nursing RN/LPN up to 16 hours per day, seven days per week (total of 112 hours a week). Hours to be used flexibly, one to 24 hours per day, not to exceed 896 hours in an eight-week period all providers combined.

Refer to Appendix 6 of this handbook for an example of requesting flexible hours.

Amending Prior Authorization Requests to Include Flexible Hours

If an existing PA request has been approved without flexibility and it is determined that the use of flexible hours would be of benefit, providers should request an amendment to the PA request and obtain new orders from the physician. The amendment must explain the reason flexibility is needed and include the specific date that use of flexible hours will start.

If a change occurs in the recipient's medical condition or a family medical crisis arises (e.g., the extended illness of a primary caregiver), and the coverage for these events cannot be accommodated within the authorized use of the flexible hours during the flexibility period, nurses may submit a request for additional hours through an amendment to the original PA request. The amendment must explain the reason for the additional hours in detail; however, most events can be accommodated through the use of flexibility.

Documentation Requirements for Private Duty Nursing Services

Providers requesting PA for PDN services are required to include the following with the PA/RF:

- The Private Duty Nursing Prior Authorization Acknowledgment, HCF 11041.
- Either the PA/HCA *or* the recipient's POC in another format that contains *all* of the components requested in the completion instructions of the PA/HCA.

Private Duty Nursing Prior Authorization Acknowledgment

Wisconsin Medicaid requires agencies to submit a completed and signed Private Duty Nursing Prior Authorization Acknowledgment with all PA requests for PDN services. This form acknowledges that the recipient or the recipient's legal representative has read the POC and PA request. The Private Duty Nursing Prior Authorization Acknowledgment is located in Appendix 1 of this handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

Documenting Expected Hours on the Prior Authorization Request Form

Providers are required to indicate the expected number of PDN hours for both RNs and LPNs per day, the number of days per week, and the number of weeks or months of service per provider on the PA/RF. The total number of PDN hours requested on the PA/RF must match the number of hours indicated on the POC. Services by another provider, whether another home health agency, NIP, or volunteer, must also be indicated on the POC. Refer to the Plan of Care chapter of this handbook for further information on the POC forms.

Shared Cases

When home health agencies are case sharing PDN services, each provider is responsible for doing the following:

- Obtaining a PA separately for the services to be performed by that provider.
- Communicating and coordinating the PA request with other case-sharing providers to assure appropriate care and reimbursement.

To reduce the chance of PA request returns and expedite the PA process, each provider is required to document specific information about the case. Wisconsin Medicaid may return the PA request if information provided is incomplete and/or inconsistent.

Providers are required to indicate the expected number of PDN hours for both RNs and LPNs per day, the number of days per week, and the number of weeks or months of service per provider on the PA/RF.

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Refer to the Online Handbook for current policy

Plan of Care

Each provider is required to indicate the following on the recipient's POC:

- The total number of home care hours that the recipient requires.
- The names of all the providers that will be sharing the case.
- The number of hours that each provider will be providing care.

Prior Authorization Request Form

Each provider is required to indicate the following in Element 19 of the PA/RF:

- The number of hours per week the provider will provide care.
- "Shared case with (name of the other provider). Total hours for all providers will not exceed total hours on POC."

Durable Medical Equipment

Refer to the Durable Medical Equipment (DME) Index on the Wisconsin Medicaid Web site and DME publications for information on requesting PA for DME.

Disposable Medical Supplies

Refer to the Disposable Medical Supplies (DMS) Index on the Wisconsin Medicaid Web site and DMS publications for information on requesting PA for DMS.

Personal Care Services

If the recipient is receiving both personal care services and home health services from the home health agency, the agency must request PA for the home health and personal care services on the same PA/RF. Services added during the term of the PA/RF must be added by amendment. For further information refer to the Personal Care Handbook.

Recipients with Changing Nursing Needs

During a recipient's course of treatment, the number of hours of nursing services he or she requires may change. As a result, the recipient may transition from home health services to PDN services or the recipient may no longer require PDN services. When a change in the level of service occurs, providers are required to submit a new PA/RF to Wisconsin Medicaid. In this situation, an amendment to the current PA/RF will not be accepted.

Recipients Changing to Private Duty Nursing

If the condition of a recipient receiving home health skilled nursing services changes to the point that eight or more hours of direct, skilled nursing care are required in a calendar day, the recipient is no longer eligible for home health skilled nursing services. For reimbursement of covered services, the provider should request PA for PDN services.

The nursing services may continue to be billed as home health skilled nursing services for a maximum of 30 calendar days. The 30-day grace period is provided to allow the provider time to submit a new PA/RF for PDN services. The 30 days begin accumulating on the first day that eight hours or more of direct, skilled nursing services become necessary. The 30-day grace period may not be used for providing any nursing services outside the recipient's home.

This 30-day period is the only time that services for a recipient requiring eight or more hours of direct, skilled nursing care per calendar day may be billed as home health skilled nursing services.

After the 30-day grace period has ended, home health skilled nursing services are no longer reimbursable for a recipient receiving eight hours or more of direct, skilled nursing services. If PA for PDN services has not been approved by the end of the 30-day grace period, only home health skilled nursing services of less than eight hours as approved on the current PA/RF will be reimbursable.

If the recipient is receiving both personal care services and home health services from the home health agency, the agency must request PA for the home health and personal care services on the same PA/RF.

Recipients Who No Longer Require Private Duty Nursing

If the condition of a recipient receiving PDN services improves to the point that less than eight hours of direct, skilled nursing care are required in a calendar day, the recipient is no longer eligible for PDN. An alternate level of care such as intermittent skilled nursing visits, home health aide visits, or personal care services may be more appropriate.

Obtaining Prior Authorization Request Forms

Providers may obtain the PA/HCA and the PA/HHTA in the following formats:

- Paper.
- Portable Document Format.
- Web PA.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on obtaining PA forms in these formats. Refer to Appendices 3 and 4 for the PA/HCA completion instructions and form and Appendices 7 and 8 for the PA/HHTA completion instructions and form.

The PA/RF is only available in paper format from Wisconsin Medicaid or in Web PA format. Refer to Appendix 10 of this handbook for PA/RF completion instructions for home health agencies.

Submitting Prior Authorization Request Forms

Providers have the following options for submitting PA requests:

- Mail.
- Fax.
- Web.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on these methods of PA submission.

Prior authorization requests may be submitted no earlier than 62 days prior to the requested effective date.

Prior Authorization Decisions

Prior authorization decisions are made within 20 working days from the receipt of *all* information necessary to process the request. After the clerical and clinical reviews of the PA request are complete, one of the following decisions is made for the PA request:

- Approved.
- Approved with modification.
- Returned to the provider for additional information or clarification.
- Denied.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on each type of decision and subsequent actions the recipient and provider may take.

Prior Authorization Effective Dates

Each approved PA request has a grant (start) date and an expiration (end) date. Prior authorization requests are approved for varying periods of time based on clinical justification submitted, but are never granted for more than a 12-month period.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on PA effective dates.

Prior Authorization Backdating

Backdating a PA request to a date prior to Wisconsin Medicaid's initial receipt of the request may be allowed in limited circumstances.

Prior authorization requests may be submitted no earlier than 62 days prior to the requested effective date.

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Initial Requests

An initial PA request may be backdated up to 14 calendar days from the first date of receipt by Wisconsin Medicaid. For backdating to be authorized, both of the following criteria must be met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.

Extraordinary Circumstances

In the following cases, a PA request *may* be backdated for more than 14 days:

- A court order or hearing decision requiring Wisconsin Medicaid coverage is attached to the PA request.
- The recipient is retroactively eligible. (Indicate in Element 19 of the PA/RF that the service was provided during a period of retroactive recipient eligibility. In Element 14, indicate the actual date the service was provided.)

Subsequent Requests Will Not Be Backdated

Wisconsin Medicaid will not backdate subsequent PA requests for continuation of ongoing services. To prevent a lapse in coverage, all subsequent PA requests must arrive at Wisconsin Medicaid prior to the expiration date of the previous PA.

Returned Requests

An initial PA request returned for additional information may be backdated 14 calendar days from the date it was initially received by Wisconsin Medicaid if the additional corrected information is returned with the original PA/RF.

Amendment Requests

Prior authorization amendment requests may be backdated 14 calendar days from the date of receipt by Wisconsin Medicaid if the request is for urgent situations in which medical necessity could not have been predicted.

Denied Requests

Once a PA request has been denied, that PA number can no longer be used. A new PA number must be used with a new request. A new request following a denial may be backdated to the original date the denied request was received by Wisconsin Medicaid when all the following criteria are met:

- The earlier grant date is requested.
- The denied PA request is referred to in writing.
- The new PA request has information to justify approval.
- The request for reconsideration submitted with additional supporting documentation is received within 14 calendar days of the adjudication date on the original denied PA request.

Amending an Approved or Modified Prior Authorization Request

Under certain circumstances, providers may amend an approved or modified PA. Examples of these types of circumstances include, but are not limited to, the following:

- The recipient's Medicaid identification number changes.
- There is a short-term change in the recipient's medical condition and the frequency of a service needs to be modified temporarily, regardless of whether it is an increase or decrease in level of care or hours. Physician orders that reflect the change are required.
- A provider reduces the number of hours of service because another provider begins to share the case. Requests for additional services by another provider may be denied if the number of services on the first PA is not reduced at the same time.

Providers may also submit a reconsideration request in the form of an amendment when a PA has been modified. Request reconsideration by submitting an amendment request with

An initial PA request may be backdated up to 14 calendar days from the first date of receipt by Wisconsin Medicaid.

When a recipient chooses to discontinue receiving prior authorized services or a provider chooses to discontinue delivering prior authorized services, the billing provider should request the PA be enddated.

additional documentation that supports the original request. The amendment request should be received within 14 calendar days of the adjudication date on the original PA/RF or amendment. If the amendment request is approved, Wisconsin Medicaid will notify the provider of the effective date.

An amendment to an approved PA/RF must be requested any time the physician orders additional care, unless the additional services can be billed without a PA number and charged against one of the 30 outstanding PA threshold visits. This includes intermittent additional care due to fluctuations in the availability of the primary caregiver.

A new PA/RF must be submitted when changing requested nursing services from home health skilled nursing or home health aide to PDN or vice versa. Do *not* submit an amendment in these circumstances.

Note: If there is a significant, long-term change that requires a new POC, then Wisconsin Medicaid recommends that providers enddate the current PA and submit a new request for PA.

The amendment request should include:

- A completed Prior Authorization Amendment Request, HCF 11042, describing the specific change requested and the reason for the request. Provide sufficient detail for Wisconsin Medicaid to determine the medical necessity of the requested services.
- A *copy* of the PA/RF to be amended (*not* a new PA/RF).

- A copy of the updated PA/HCA, recipient's POC in another format that contains *all* of the components requested in the PA/HCA Completion Instructions, or the physician's orders. If current orders continue to be compatible with the new request, new orders are not necessary.
- Additional supporting materials or medical documentation explaining or justifying the requested changes.

The completion instructions and Prior Authorization Amendment Request are located in Appendices 15 and 16 of this handbook for photocopying and may also be downloaded from the Medicaid Web site.

Enddating a Prior Authorization Request

When a recipient chooses to discontinue receiving prior authorized services or a provider chooses to discontinue delivering prior authorized services, the billing provider should request the PA be enddated. This will facilitate the recipient's eligibility for other care, if necessary.

To enddate a PA, the provider should submit an amendment request and amend the expiration date of the PA to show the actual date of discharge.

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Claims Submission

To receive reimbursement, claims and adjustment requests must be received by Wisconsin Medicaid within 365 days of the date of service (DOS). To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received by Wisconsin Medicaid within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later.

For more information about exceptions to the claims submission deadline, Medicaid remittance information, adjustment requests, and returning overpayments, refer to the Claims Information section of the All-Provider Handbook.

Reimbursement

Home health aide services, home health skilled nursing services, and home health therapy services are reimbursed according to a maximum allowable fee per visit. Private duty nursing services are reimbursed based on an hourly maximum allowable fee. Providers may obtain a maximum allowable fee schedule on the Wisconsin Medicaid Web site or by contacting Provider Services at (800) 947-9627 or (608) 221-9883.

Coordination of Benefits

Wisconsin Medicaid is generally the payer of last resort and reimburses the portion of the allowable cost remaining after all other third-party sources have been exhausted.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services requiring other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159.

Coverage Determination Software

Coverage determination software (CDS) helps home health providers identify when they should bill Medicare before billing Wisconsin Medicaid for dual entitlements. Providers may use the following instructions to download the Windows 98/NT-compatible CDS free of charge from the Wisconsin Medicaid Web site:

- Go to dhfs.wisconsin.gov/medicaid/.
- Select the “Providers” link at the top of the page.
- Choose “Home Health Agencies” from the Information Listed by Provider Type pull-down menu and select “GO.”
- Select “Resources.”
- Select “CDS.”

Agency Requirements

Home health agencies are required to use the CDS for recipients who are dual eligibles. Providers are required to use the CDS as follows:

- Use the CDS before the agency provides Medicaid services.
- Use the CDS when a recipient’s condition or status changes, potentially making the recipient eligible for Medicare coverage.
- Keep a printed copy of the results of the software’s determination on file and on the agency’s premises for audit purposes.

It is important to use CDS when one agency is sharing a case with another agency. If skilled care is provided by another agency, the recipient may be eligible for Medicare home health care through that agency. In that situation, a Medicare-certified provider is required to bill Medicare for those services covered by Medicare.

Coverage determination software (CDS) helps home health providers identify when they should bill Medicare before billing Wisconsin Medicaid for dual entitlements.

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Medicaid Is Payer of Last Resort

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Federal law prohibits home health services that are covered by Medicare to be paid by Medicaid. The Centers for Medicare and Medicaid Services accepts the CDS-printed results as documentation that Medicaid is the payer of last resort. If the agency submits claims to Wisconsin Medicaid for services that Medicare pays home health agencies to provide, Wisconsin Medicaid will audit and recoup Medicaid payments.

Although the CDS does not ask questions about a recipient's other insurance coverage, providers are required to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid.

Claims Submission Options

When billing Wisconsin Medicaid, providers may submit claims electronically or on paper. All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Providers are encouraged to submit claims electronically. Electronic claims submission does the following:

- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Allows flexible submission methods.
- Adapts to existing systems.
- Reduces clerical effort.

For further information on submitting claims electronically, providers should refer to the Claims Information section of the All-Provider Handbook.

Providers are required to submit a paper claim, not an electronic claim, when the claim requires additional documentation.

Paper Claims Submission

Providers submitting paper claims for home health services are required to use the UB-92 claim form. Wisconsin Medicaid denies claims for home health services that are submitted on any paper claim form other than the UB-92 claim form. Refer to Appendices 22-26 of this handbook for completion instructions and sample claims.

Photocopied claims are acceptable for submission as long as the claims are legible. Do not attach documentation to the claim unless it is specifically required by Wisconsin Medicaid.

To expedite processing of paper claims, follow these suggestions:

- Supply all data accurately.
- Supply all data in a legible manner on the face of the claim form, by printing or typing information.
- Follow exactly the claim form instructions found in this handbook or subsequent Wisconsin Medicaid and Badgercare provider publications.

Mail completed claims to the following address:

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

Obtaining the UB-92 Claim Form

Wisconsin Medicaid does not supply the UB-92 claim form. Forms may be obtained from a number of commercial form suppliers.

Disposable Medical Supplies and Enteral Nutrition Products

Providers submitting paper claims for disposable medical supplies (DMS) and enteral nutrition products and supplies are required to use the CMS 1500 claim form. Refer to the DMS Index for a list of valid procedure codes and the Disposable Medical Supplies Handbook for further information on submitting paper claims for DMS and enteral nutrition products and supplies.

When billing Wisconsin Medicaid, providers may submit claims electronically or on paper.

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the DOS. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the All-Provider Handbook for claims submission deadline exceptions and submission requirements.

Follow-up to Claims Submission

It is the provider's responsibility to initiate follow-up procedures on claims submitted to Wisconsin Medicaid. The Medicaid remittance information indicates processed claims either as paid, pending, or denied.

Wisconsin Medicaid does not take any further action on a denied claim until the provider corrects the information and resubmits the claim. If Wisconsin Medicaid pays a claim incorrectly, the provider is responsible for submitting an Adjustment/Reconsideration Request form, HCF 13046, to Wisconsin Medicaid. Refer to the All-Provider Handbook for detailed information regarding the following:

- Adjustment requests.
- Denied claims.
- Good Faith claims.
- Overpayments.
- Remittance information.

Providers may contact Provider Services with questions regarding delays in payment or other claims submission questions. The Adjustment/Reconsideration Request form is available on the Forms page of the Wisconsin Medicaid Web site.

It is the provider's responsibility to initiate follow-up procedures on claims submitted to Wisconsin Medicaid.

Special Circumstances

Billing Prior Authorized Services with Non-Prior Authorized Services

Claims for services provided under a prior authorization (PA) number may be submitted on the same claim as claims for services not requiring PA. However, an exception applies if a service with the same procedure code is provided outside the grant and expiration dates on the PA and then again between the grant and expiration dates on the PA. These services cannot be submitted on a single claim form or Wisconsin Medicaid will deny the claim. Two separate claims must be submitted for services in this situation; one for services provided outside the grant and expiration dates and one for services provided between these dates.

For example, a home health physical therapy (PT) visit (procedure code 97799) that counts toward the 30-visit threshold for the calendar year is made to a recipient on February 3, 2005, and therefore does not require PA. Beginning on February 7, 2005, the recipient has an approved PA to receive home health PT (procedure code 97799) because all of the 30 threshold visits for the calendar year have been used. When the physical therapist makes a visit to provide services on February 10, 2005, the service must be billed on a separate claim form from the February 3, 2005 visit because the February 3, 2005 visit falls outside the PA grant and expiration dates for that procedure code. Billing the two visits on the same claim form would cause the claim to be denied.

Billing Across Midnight

Providers are required to bill for each DOS that care was provided. If a nurse provides care for a recipient across midnight, *the nurse is required to split the billing over two DOS since the shift extends over two dates.* This means that two modifiers must be used, one for the hours of the shift occurring before midnight, and another to designate the hours of the shift occurring after midnight on the next calendar day.

For example, if a nurse begins care for a recipient at 8:00 p.m. on December 1 and ends care at 4:00 a.m. on December 2, the agency should bill for four hours of care on December 1 with modifier “UH” and four hours of care on December 2 with modifier “UJ.” Refer to Appendix 24 of this handbook for a sample claim form of two shifts spanning midnight.

Daylight Savings Time

Wisconsin Medicaid reimburses only for the number of hours actually worked. Providers who work when daylight savings time ends are still required to adhere to the limitations on authorized services. Authorization is limited to 12 hours in each 24-hour period and 60 hours in a calendar week for any one nurse. Nurses are expected to adjust their schedules in advance to accommodate changes in the clock time.

A Authorization is limited to 12 hours in each 24-hour period and 60 hours in a calendar week for any one nurse.

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Codes for Prior Authorization and Claims

This chapter contains information about the codes required for certain components of prior authorization (PA) requests and claims submission.

Providers may refer to Appendix 10 for complete instructions on completing a paper Prior Authorization Request Form (PA/RF), HCF 11018. Sample PA/RFs are included in Appendices 11-14 of this handbook. Refer to the Wisconsin Medicaid Web site for information on completing PA requests electronically via the Web.

Complete UB-92 claim form completion instructions can be found in Appendix 22 of this handbook, and sample UB-92 claim forms can be found in Appendices 23-26 of this handbook. Refer to the Claims Information section of the All-Provider Handbook for information on completing claims electronically via the Web.

Revenue Codes

Providers are required to use a revenue code when submitting claims to Wisconsin Medicaid. Refer to Appendix 18 for a list of revenue code examples. For the most current and complete list of revenue codes, contact the American Hospital Association National Uniform Billing Committee. Providers should use the appropriate revenue code that best describes the service performed.

Place of Service

When submitting PA requests, providers are required to include a place of service (POS) code. Refer to Appendix 20 of this handbook for a list of nationally recognized POS codes.

Date of Service

Under specific circumstances, providers may enter up to four dates of service (DOS) on one line for each revenue and procedure code when submitting claims. If billing multiple DOS on a single line (series billing), refer to the instructions in Form Locator 43 of the UB-92 claim form instructions in Appendix 22 of this handbook. *All* conditions outlined in Form Locator 43 must be followed when series billing.

Procedure Codes

When submitting PA requests and claims, home health providers may use the Healthcare Common Procedure Code System procedure codes listed in Appendix 19 of this handbook. Providers should refer to the Durable Medical Equipment (DME) Index for a list of valid procedure codes for DME. Providers should refer to the Disposable Medical Supplies (DMS) Index for a list of valid procedure codes for DMS.

Home health agencies providing services to ventilator-dependent recipients may use the *Current Procedural Terminology* procedure codes listed in Appendix 19 of this handbook on PA requests and claims.

Modifiers

Home health providers are required to use nationally recognized modifiers with procedure codes on PA requests and claims forms. Refer to Appendix 19 of this handbook for a complete list of all modifiers, their definitions, and the procedure codes to which they apply. No more than four modifiers can be entered for each day on the claim form.

Home health providers are required to use nationally recognized modifiers with procedure codes on PA requests and claims forms.

Start-of-Shift Modifiers

Providers are required to use state-defined start-of-shift modifiers on claims. Start-of-shift modifiers are not required on PA requests.

Providers should choose the start-of-shift modifier that most closely represents the time each shift began. For each day, enter the modifiers in the order of occurrence. If a single shift spans over midnight from one day to the next, providers are required to use two start-of-shift modifiers. Refer to the Claims Submission chapter of this handbook for more information about billing across midnight.

Professional Status Modifiers

Home health agencies that provide private duty nursing (PDN) services to ventilator-dependent recipients are required to use one of two nationally recognized modifiers to indicate a nurse's professional status. Professional status modifiers are required on PA requests and claims.

Units of Service

The number of services (visits or hours) billed must be listed on each detail line of the claim form.

Home health aide visits, home health skilled nursing visits, and home health therapy visits are billed as one unit of service per day. If the quantity billed is not an increment of a whole unit, the service is denied.

Private duty nursing services are rounded and billed in half-hour increments. The rounding guidelines for PDN services are as follows:

- If the visit ends in an increment between one and 30 minutes in length, the provider should round the time to 30 minutes and bill the service as a quantity of .5.
- If the visit ends in an increment over 30 minutes in length, the provider should round up or down to the nearest 30-minute increment, using the common rules of rounding listed in Appendix 21 of this handbook.

Prior Authorization Number

Each PA request is assigned a unique seven-digit number. This PA number must be indicated on a claim for the service because it identifies the service as one that has been prior authorized. Providers are responsible for including the correct PA number on the claim form. Only one PA number is allowed per claim.

Diagnosis Code

Providers are responsible for submitting PA requests and claims using the most current diagnosis codes. Claims submitted using outdated or incorrect codes will be returned to the provider.

All claims for services provided to ventilator-dependent recipients must list *International Classification of Diseases, Ninth Revision, Clinical Modification* code V46.11 (Dependence on respirator, status) as the primary diagnosis code on the claim form. Wisconsin Medicaid will not reimburse claims for respiratory services without this code.

Home health services claims that do not include services provided to a ventilator-dependent recipient do not require a specific diagnosis code.

The number of services (visits or hours) billed must be listed on each detail line of the claim form.

A Appendix

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Appendix 1
Private Duty Nursing Prior Authorization Acknowledgment
(for photocopying)

(A copy of the Private Duty Nursing Prior Authorization Acknowledgment is located on the following page.)

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Appendix

**WISCONSIN MEDICAID
PRIVATE DUTY NURSING PRIOR AUTHORIZATION ACKNOWLEDGMENT**

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. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form.

INSTRUCTIONS

1. Allow the recipient, or recipient's parent, guardian, or legal representative, to read the plan of care and prior authorization (PA) request. Answer any questions the recipient may have.
2. Have the recipient or the recipient's legal representative sign and date this form.
3. Attach this completed form to the Prior Authorization Request Form (PA/RF), HCF 11018, and/or Prior Authorization Amendment Request, HCF 11042.
4. For more information on private duty nursing documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

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Name — Recipient	Recipient Medicaid Identification Number
Prior Authorization Number	

I have read the attached Plan of Care and the PA request.

Name — Person Signing Form (Print)	Relationship to Recipient (If Person Signing Form Is Not Recipient)
SIGNATURE — Person Signing Form Check one of the following to identify person signing form. <input type="checkbox"/> Recipient <input type="checkbox"/> Recipient's Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Representative	Date Signed

Appendix 2

Wisconsin Medicaid Private Duty Nursing — A Guide for Wisconsin Medicaid Recipients and Their Families (for photocopying)

(A copy of the Wisconsin Medicaid Private Duty Nursing — A Guide for Wisconsin Medicaid Recipients and Their Families brochure is located on the following pages.)

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QUESTIONS AND ANSWERS ABOUT PDN

IS IT POSSIBLE TO APPEAL A PRIOR AUTHORIZATION DECISION?

- You may appeal a prior authorization decision by requesting a fair hearing before an independent administrative hearing officer.
- Before beginning the appeal process, you should discuss the decision with your provider to make sure that the provider submitted all the necessary information in the prior authorization request.
- If additional information or corrections are needed, the provider may submit the prior authorization request for reconsideration.

WHAT IF CHANGES OCCUR IN YOUR NEEDS OR THE FAMILY'S ABILITY TO PROVIDE CARE AFTER THE PDN SERVICES ARE APPROVED?

- If changes occur, inform your PDN provider, who will then notify your physician and Wisconsin Medicaid.
- The Plan of Treatment can be modified and the PA Request may be amended with the approval of the Medicaid consultants.
- The Plan of Treatment must be re-evaluated and signed by your physician every 62 days, even if no changes occur.

ARE THERE LIMITS ON HOW MANY HOURS OF PDN CARE A RECIPIENT MAY RECEIVE?

Yes. PDN only covers the time spent by a licensed nurse performing skilled nursing tasks. If additional health care is authorized, family and PDN care may be supplemented by home health aides and personal care workers. Together, you, your family, and the PDN provider(s) should discuss how these hours will be coordinated.

CAN PDN RECIPIENTS USE THEIR AUTHORIZED HOURS FLEXIBLY?

Yes. You may use your authorized PDN hours flexibly over periods of time up to eight weeks in length. If you choose flexible scheduling, the provider(s) will indicate this preference in the prior authorization request or in an amendment to the existing prior authorization.

Flexible use of PDN hours allows most recipients to accommodate changes in family schedules, or unscheduled provider absences, hospitalizations, or other unforeseen needs.

WHAT IF A PROVIDER CANNOT MEET A RECIPIENT'S NEED FOR FLEXIBLE HOURS?

If an agency or individual provider is unable to meet your needs for flexibility, you may wish to work with additional PDN providers to ensure coverage of all the PDN hours authorized. Providers should include a provision regarding flexible time in your service agreement with them.

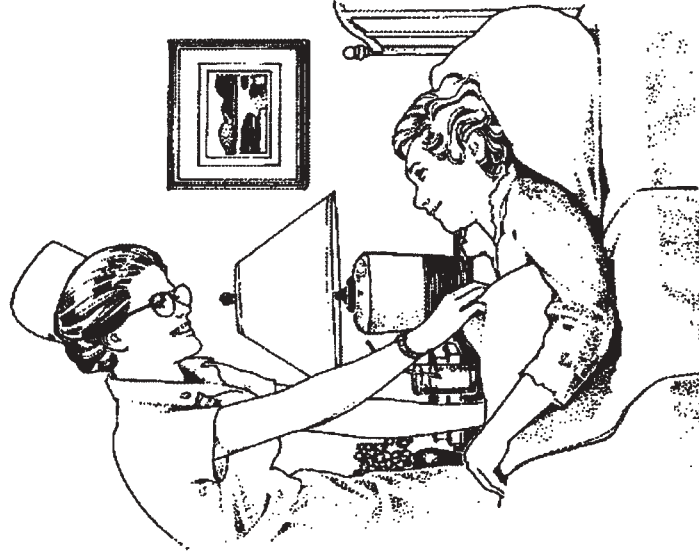
WHERE CAN RECIPIENTS GET MORE INFORMATION OR VOICE ANY CONCERNS THEY MAY HAVE ABOUT THEIR PDN CARE?

You can contact Medicaid Recipient Services by calling 1-800-362-3002 toll-free or 608-221-5720. Medicaid Recipient Services can:

- Answer questions about Medicaid coverage.
- Refer you to Medicaid-certified providers in your area.
- Refer you to state agencies that regulate the performance of home health care professionals.

Wisconsin Department of Health and Family Services
Division of Health Care Financing
POH 1122
April 1999

WISCONSIN MEDICAID



Private Duty Nursing

A GUIDE FOR
WISCONSIN MEDICAID RECIPIENTS AND
THEIR FAMILIES



ABOUT WISCONSIN MEDICAID PRIVATE DUTY NURSING

Wisconsin Medicaid covers private duty nursing (PDN) for recipients with medical conditions that require eight or more hours of skilled nursing care in a 24-hour period.

- PDN supplements the care families and other health professionals are able to provide in the home.
- PDN services are generally provided in a recipient's home. However, PDN may also be provided outside the home if the recipient's normal activities, like school or work, require him/her to leave home.
- Recipients may use their authorized daily hours of PDN care flexibly over periods of time up to 8 weeks in length.
- The number of PDN hours covered daily is based on medical need and must be prior authorized by Wisconsin Medicaid medical consultants.
- Only Medicaid-certified home health agencies or independent nurses may provide Medicaid PDN.



GUIDING RECIPIENTS THROUGH THE PROCESS

If it appears that you, the Medicaid recipient, may qualify for PDN services, the PDN provider will work with you and your physician to help you get the care you need.

If you do not require eight or more hours of skilled nursing care in a day, the PDN provider can refer you to providers of part-time intermittent skilled nursing care.

PLAN OF TREATMENT

The PDN provider will work with you and your physician to develop a Plan of Treatment, sometimes called a Plan of Care. A Plan of Treatment includes:

- A medical assessment.
- Medication and treatment orders.
- Treatment goals.
- Methods of care to be used.
- Plan for care coordination by nurses and other health professionals.

FAMILY SUPPORT

The PDN provider will ask questions about your family support needs, including:

- Your family's ability to provide medical care.
- Daily schedules — including hours of work, school, sleep, and care for other family dependents.



GUIDING RECIPIENTS THROUGH THE PROCESS (CONT.)

REQUEST FOR PRIOR AUTHORIZATION

Based on the Plan of Treatment and the family support information, the provider will:

- Prepare a written prior authorization request.
- Obtain a signed statement from you or a responsible family member saying that you or he/she has read both the Plan of Treatment and the Prior Authorization Request.
- Submit the Prior Authorization Request and the Plan of Treatment to the Medicaid medical consultants who will review the request.

APPROVAL OF PDN

Medicaid medical consultants will review a request for prior authorization of PDN services within two weeks after it is received.

- If the information is not complete, the Prior Authorization Request will be returned to the provider.
- If the information is complete, the request will be approved, modified, or denied.
- If the request is modified or denied, you will receive a letter explaining the reason for the decision and what further steps you may take.

Appendix 3
Prior Authorization/Home Care Attachment (PA/HCA)
Completion Instructions
(for photocopying)

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

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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)
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 Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096, is a plan of care (POC) that may be completed for Wisconsin Medicaid recipients receiving home care services. The information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all the components requested on this form. If necessary, attach additional pages if more space is needed. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Retain the original, signed PA/HCA. Attach a copy of the PA/HCA to the Prior Authorization Request Form (PA/RF), HCF 11018, and submit it to Wisconsin Medicaid along with any attached additional information. 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

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The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Prior Authorization Number

Enter the unique seven-digit number from the PA/RF. Enter the same PA number in the spaces provided at the top of each subsequent page of the form.

Element 2 — Name and Telephone Number — Recipient

Enter the name and telephone number, including the area code, of the recipient. If the recipient's telephone number is not available, enter "N/A."

Element 3 — Start of Care Date

Enter the date that covered services began for the recipient in MM/DD/YY format (e.g., March 13, 2005, would be 03/13/05). The start of care date is the date of the recipient's first billable home care visit. This date remains the same on subsequent POC until the recipient is discharged.

Element 4 — Certification Period

Enter the beginning and ending dates of the recipient's certification period respectively in the "From" and "To" portions of this element in the MM/DD/YY format. The certification period identifies the period of time approved by the attending physician for the POC.

The "To" date can be *up to*, but not more than, 62 days later than the "From" date. (Medicare certified agencies should use the timeframe of up to, but not more than 60 days later.) For certification periods that cover consecutive 31-day months, providers should be careful not to exceed 62 days.

Services provided on the "To" date are included in the certification period. On subsequent periods of recertification, the certification period should begin with the day directly following the date listed as the "To" date in the immediately preceding certification period.

Example:

Initial Certification Period	
"From" date	12/01/04
"To" date	01/31/05

Subsequent Recertification Period	
"From" date	02/01/05
"To" date	04/03/05

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

Element 5 — Principal Diagnosis

Enter the principal diagnosis information. Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code, diagnosis code description, and the date of onset in MM/DD/YY format. If the recipient's condition is chronic or long-term in nature, use the date of exacerbation.

Element 6 — Surgical Procedure and Other Pertinent Diagnoses

Enter the surgical procedure information, if any, that is relevant to the care rendered or the services requested. Include the appropriate ICD-9-CM diagnosis code, diagnosis code description, and the date of the surgical procedure in MM/DD/YY format. The month and year of the date of the surgical procedure must be included. Use "00" if the exact day of the month is unknown (e.g., March 2005, would be 03/00/05).

Enter all other diagnoses pertinent to the care rendered for the recipient. Include the appropriate narrative or ICD-9-CM diagnosis code, code description, and the date of onset in MM/DD/YY format. Include all conditions that coexisted at the time the POC was established or that subsequently developed. Exclude conditions that relate to an earlier episode not associated with this POC. Other pertinent diagnoses in this element may be changed to reflect changes in the recipient's condition.

If a relevant surgical procedure was not performed and there are no other pertinent diagnoses, enter "N/A" (do not leave the element blank).

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

Element 7 — Durable Medical Equipment

Identify the item(s) of durable medical equipment (DME) ordered by the attending physician and currently used by the recipient. Enter "N/A" if no known DME has been ordered.

Element 8a — Functional Limitations

Enter an "X" next to all items that describe the recipient's current limitations as assessed by the attending physician and the nurse or therapist. If "Other" is checked, provide further explanation in Element 8b.

Element 8b

If "Other" is checked in Element 8a, specify the other functional limitations.

Element 9a — Activities Permitted

Enter an "X" next to all activities that the attending physician permits and/or that are documented in the attending physician's orders. If "Other" is checked, provide further explanation in Element 9b.

Element 9b

If "Other" is checked in Element 9a, specify the other activities the recipient is permitted.

Element 10 — Medications

Enter the attending physician's orders for all of the recipient's medications, including the dosage, frequency, and route of administration for each. If any of the recipient's medications cause severe side effects or reactions that necessitate the presence of a nurse, therapist, home health aide, or personal care worker, indicate the details of these circumstances in this element.

Element 11 — Allergies

List any medications or other substances to which the recipient is allergic (e.g., adhesive tape, iodine, specific types of food). If the recipient has no known allergies, indicate "no known allergies."

Element 12 — Nutritional Requirements

Enter the attending physician's instructions for the recipient's diet. Include specific dietary requirements, restrictions, fluid needs, tube feedings, and total parenteral nutrition.

Element 13 — Mental Status

Enter an "X" next to the term(s) that most accurately describes the recipient's mental status. If "Other" is checked, provide further explanation.

Element 14 — Prognosis

Enter an "X" next to the one term that specifies the most appropriate prognosis of the recipient.

SECTION IV — ORDERS

Element 15 — Orders for Services and Treatments

Indicate the following as appropriate for each individual service:

- Number of recipient visits (e.g., home health skilled nursing, home health aide, or medication management), frequency of visits, and duration of visits ordered by the attending physician's orders (e.g., 1 visit, 3 times/week, for 9 weeks).
- Number of hours required for recipient visits (e.g., private duty nursing [PDN] or personal care), frequency of visits, and duration of visits ordered by the attending physician's orders (e.g., 8 hours/day, 7 days/week, for 9 weeks).
- Duties and treatments to be performed.
- Methods for delivering care and treatments.
- Procedures to follow in the event of accidental extubation, as applicable.
- Ventilator settings and parameters, as applicable.

Services include, but are not limited to, the following:

- Home health skilled nursing.
- Home health aide.
- Private duty nursing.

Orders must include all disciplines providing services for the recipient and all treatments the recipient receives regardless of whether or not the services are billable to Wisconsin Medicaid. Orders indicated on this POC should be as detailed and specific as those ordered and written by the attending physician.

Pro re nata (PRN), or "as needed," home care visits or hours may be ordered on a recipient's POC only when indicating how these visits or hours will be used in a manner that is specific to the recipient's potential needs. Both the nature of the services provided and the number of PRN visits or hours to be permitted for each type of service *must* be specified. Open-ended, unqualified PRN visits or hours do not constitute an attending physician's orders because both the nature and frequency of the visits or hours *must* be specified.

Nurses in independent practice (NIP) are required to include the name and license number of the registered nurse (RN) providing coordination services under this element. An NIP that is a licensed practical nurse is required to include the name and license number of the RN supervisor under this element.

Element 16 — Goals / Rehabilitation Potential / Discharge Plans

Enter the attending physician's description of the following:

- Achievable and measurable goals for the recipient.
- The recipient's ability to attain the set goals, including an estimate of the length of time required to attain the goals.
- Plans for the recipient's care after discharge.

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

Element 17 — Date Physician Last Saw Recipient

Enter the date the attending physician last saw the recipient in MM/DD/YY format. If this date cannot be determined during the home visit, enter "Unknown."

Element 18 — Dates of Last Inpatient Stay Within 12 Months

Enter the admission and discharge dates of the recipient's last inpatient stay within the previous 12 months, if known. Enter "N/A" if this element does not apply to the recipient.

Element 19 — Type of Facility for Last Inpatient Stay

Enter one of the following single-letter responses to identify the type of facility of the recipient's last inpatient stay, if applicable:

- A (Acute hospital).
- S (Skilled nursing facility).
- R (Rehabilitation hospital).
- I (Intermediate care facility).
- O (Other).
- U (Unknown).

This element must be completed if a surgical procedure was entered in Element 6. Enter "N/A" if this element does not apply to the recipient.

Element 20 — Current Information

For initial certifications, enter the clinical findings of the initial assessment visit for each discipline involved in the POC. Describe the clinical facts about the recipient that require home care services and include specific dates in MM/DD/YY format.

For recertifications, enter significant clinical findings about the recipient's symptoms, new orders, new treatments, and any changes in the recipient's condition during the past 60 days for each discipline involved in the POC. Document both progress and nonprogress for each discipline. Include specific dates in MM/DD/YY format.

Include any pertinent information about any of the recipient's inpatient stays and the purpose of contact with the physician, if applicable.

Element 21 — Home or Social Environment

Enter information that will justify the need for home care services and enhance the Wisconsin Medicaid consultant's understanding of the recipient's home situation (e.g., recipient lives with mentally disabled son who is unable to provide care or assistance to recipient). Include the availability of caretakers (e.g., parent's work schedule). The description may document problems that are, or will be, an impediment to the effectiveness of the recipient's treatment or rate of recovery.

Element 22 — Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home

Enter all reasons that the recipient leaves home. Indicate both medical and nonmedical reasons, including frequency of occurrence of the trips (e.g., doctor appointment twice a month, barbershop once a month, school every weekday for three hours).

Element 23 — Back-up for Staffing and Medical Emergency Procedures

This element is required for all providers requesting PDN services. It is optional for all other home care providers.

Enter the back-up plan for staffing and medical emergency procedures. The following information must be included in this element:

- A plan for medical emergency, including:
 - ✓ A description of back-up personnel needed.
 - ✓ Provision for reliable, 24 hours a day, 7 days a week emergency service for repair and delivery of equipment.
 - ✓ Specification of an emergency power source.
- A plan to move the recipient to safety in the event of fire, flood, tornado warning or other severe weather, or any other condition which threatens the recipient's immediate environment.

SECTION VI — SIGNATURES

Those signing the POC are to acknowledge their responsibilities and consequences for non-compliance. Provider-created formats must contain the following statement that is included on the PA/HCA:

"Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal law."

Element 24 — Signature — Authorized Nurse Completing Form

The nurse completing this PA/HCA is required to sign this form. The signature certifies that the nurse has received authorization from the attending physician to begin providing services to the recipient.

Provider-created formats must contain the following statement accompanying the authorized nurse's signature:

"As the nurse completing this plan of care, I confirm the following: All information entered on this form is complete and accurate. I am familiar with all information entered on this form. I am responsible for ensuring that the plan of care is carried out as specified. I have received authorization from the attending physician to provide services to the recipient. I have reviewed the information in this document with the attending physician on the date specified."

(The date specified refers to the date requested in Element 25.)

Element 25 — Date Reviewed with Attending Physician

Enter the date the nurse signing in Element 24 reviewed the information contained in this document with the attending physician.

Element 26 — Date Received Physician-Signed Form

Enter the date the PA/HCA signed by the attending physician was received by the nurse or in the agency.

Element 27 — Name and Address — Attending Physician

Enter the attending physician's name and complete address. The street, city, state, and zip code must be included. The attending physician establishes the POC, certifies, and recertifies the medical necessity of the visits and/or services provided.

Elements 28 and 29 — Signature and Date Signed — Attending Physician

The attending physician is required to sign and date the PA/HCA within 20 working days following the initial start of care. A recertification of the POC requires the attending physician to sign and date the new PA/HCA prior to the continued provision of services to the recipient.

Provider-created formats must contain the following statement accompanying the attending physician's signature:

"The recipient is under my care, and I have authorized the services on this plan of care."

Verbal authorization may be obtained from the attending physician for the initial certification period PA request. The recipient may then begin receiving home care services; however, the attending physician is required to sign the PA/HCA within 20 working days of the start of care date.

The attending physician may not give verbal authorization for certification period renewal PA requests. The attending physician is required to sign the PA/HCA prior to the continued provision of services to the recipient; home care services may not be provided until the attending physician's signature is obtained on the form.

The form may be signed by another physician who is authorized by the attending physician to care for the recipient in his or her absence.

The nurse or agency staff may not predate the PA/HCA for the attending physician or write the date in the field after it has been returned. If the attending physician has left Element 29 blank, the nurse or agency staff should enter the date the signed PA/HCA was received in Element 26.

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Appendix 4
Prior Authorization/Home Care Attachment (PA/HCA)
(for photocopying)

ARCHIVAL USE ONLY
(A copy of the Prior Authorization/Home Care Attachment [PA/HCA] is located on the following pages.)
Refer to the Online Handbook
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**WISCONSIN MEDICAID
 PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)**

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for detailed information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Prior Authorization Number	2. Name and Telephone Number — Recipient
3. Start of Care Date	4. Certification Period From _____ To _____

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)
--	--

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment

<p>8a. Functional Limitations</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">1 <input type="checkbox"/> Amputation</td> <td style="width:33%;">5 <input type="checkbox"/> Paralysis</td> <td style="width:33%;">9 <input type="checkbox"/> Legally Blind</td> </tr> <tr> <td>2 <input type="checkbox"/> Bowel / Bladder (Incontinence)</td> <td>6 <input type="checkbox"/> Endurance</td> <td>10 <input type="checkbox"/> Dyspnea with Minimal Exertion</td> </tr> <tr> <td>3 <input type="checkbox"/> Contracture</td> <td>7 <input type="checkbox"/> Ambulation</td> <td>11 <input type="checkbox"/> Other (Specify in Element 8b)</td> </tr> <tr> <td>4 <input type="checkbox"/> Hearing</td> <td>8 <input type="checkbox"/> Speech</td> <td></td> </tr> </table> <p>9a. Activities Permitted</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">1 <input type="checkbox"/> Complete Bedrest</td> <td style="width:33%;">6 <input type="checkbox"/> Partial Weight Bearing</td> <td style="width:33%;">10 <input type="checkbox"/> Wheelchair</td> </tr> <tr> <td>2 <input type="checkbox"/> Bedrest BRP</td> <td>7 <input type="checkbox"/> Independent at Home</td> <td>11 <input type="checkbox"/> Walker</td> </tr> <tr> <td>3 <input type="checkbox"/> Up As Tolerated</td> <td>8 <input type="checkbox"/> Crutches</td> <td>12 <input type="checkbox"/> No Restrictions</td> </tr> <tr> <td>4 <input type="checkbox"/> Transfer Bed / Chair</td> <td>9 <input type="checkbox"/> Cane</td> <td>13 <input type="checkbox"/> Other (Specify in Element 9b)</td> </tr> <tr> <td>5 <input type="checkbox"/> Exercises Prescribed</td> <td></td> <td></td> </tr> </table>	1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	2 <input type="checkbox"/> Bowel / Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	10 <input type="checkbox"/> Dyspnea with Minimal Exertion	3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	11 <input type="checkbox"/> Other (Specify in Element 8b)	4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	10 <input type="checkbox"/> Wheelchair	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent at Home	11 <input type="checkbox"/> Walker	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	12 <input type="checkbox"/> No Restrictions	4 <input type="checkbox"/> Transfer Bed / Chair	9 <input type="checkbox"/> Cane	13 <input type="checkbox"/> Other (Specify in Element 9b)	5 <input type="checkbox"/> Exercises Prescribed			<p>8b. If "Other" checked in Element 8a, specify other functional limitations.</p> <p>9b. If "Other" checked in Element 9a, specify other activities permitted.</p>
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind																										
2 <input type="checkbox"/> Bowel / Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	10 <input type="checkbox"/> Dyspnea with Minimal Exertion																										
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	11 <input type="checkbox"/> Other (Specify in Element 8b)																										
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech																											
1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	10 <input type="checkbox"/> Wheelchair																										
2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent at Home	11 <input type="checkbox"/> Walker																										
3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	12 <input type="checkbox"/> No Restrictions																										
4 <input type="checkbox"/> Transfer Bed / Chair	9 <input type="checkbox"/> Cane	13 <input type="checkbox"/> Other (Specify in Element 9b)																										
5 <input type="checkbox"/> Exercises Prescribed																												

10. Medications (Dose / Frequency / Route)

11. Allergies

12. Nutritional Requirements

13. Mental Status	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other _____
14. Prognosis	1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good
				5 <input type="checkbox"/> Excellent

Prior Authorization Number

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

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16. Goals / Rehabilitation Potential / Discharge Plans

Prior Authorization Number

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Recipient	18. Dates of Last Inpatient Stay Within 12 Months (If Known) Admission Discharge	19. Type of Facility for Last Inpatient Stay (If Applicable)
---------------------------------------	---	--

20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

21. Home or Social Environment

22. Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home (Include Frequency)

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23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

SECTION VI — SIGNATURES

Nurse Certification

As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate. I am familiar with all information entered on this form. I am responsible for ensuring that the plan of care is carried out as specified. I have received authorization from the attending physician to provide services to the recipient. I have reviewed the information in this document with the attending physician on the date specified. (The date specified refers to the date entered in Element 25 of this form.)

24. SIGNATURE — Authorized Nurse Completing Form	25. Date Reviewed with Attending Physician	26. Date Received Physician-Signed Form
---	--	---

Physician Certification

The recipient is under my care, and I have authorized the services on this PA/HCA.

27. Name and Address — Attending Physician (Street, City, State, Zip Code)

28. SIGNATURE — Attending Physician	29. Date Signed — Attending Physician
--	---------------------------------------

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

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Appendix 5

Sample Prior Authorization/Home Care Attachment (PA/HCA) for a Home Health Skilled Nursing Services Shared Case

(A sample copy of the Prior Authorization/Home Care Attachment [PA/HCA] for home health skilled nursing services is located on the following pages.)

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**WISCONSIN MEDICAID
 PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)**

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for detailed information on completing this form.

SECTION I — RECIPIENT INFORMATION	
1. Prior Authorization Number 1234567	2. Name and Telephone Number — Recipient I.M. Recipient (987) 654-3210
3. Start of Care Date 04/02/05	4. Certification Period From 04/02/05 To 06/01/05
SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED	
5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis) 401.9 Hypertension, 04/01/05	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses) 250.02 Diabetes Type II, 02/01/04 436.0 Cerebrovascular Disease, 07/09/04 251.2 Hypoglycemia, 04/01/05
SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION	
7. Durable Medical Equipment glucometer, rolling walker, bedside commode	
8a. Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel / Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance 10 <input type="checkbox"/> Dyspnea with Minimal Exertion 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation 11 <input type="checkbox"/> Other (Specify in Element 8b) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech	8b. If "Other" checked in Element 8a, specify other functional limitations.
9a. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing 10 <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent at Home 11 <input checked="" type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches 12 <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed / Chair 9 <input type="checkbox"/> Cane 13 <input type="checkbox"/> Other (Specify in Element 9b) 5 <input type="checkbox"/> Exercises Prescribed	9b. If "Other" checked in Element 9a, specify other activities permitted.
10. Medications (Dose / Frequency / Route) Vasotec 10mg BID PO Furosemide 40 mg BID PO Digoxin 0.25mg QOD PO Glucophage 500mg daily PO	
11. Allergies No known allergies.	
12. Nutritional Requirements 1800 ADA diet, NAS	
13. Mental Status 1 <input checked="" type="checkbox"/> Oriented 3 <input checked="" type="checkbox"/> Forgetful 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 2 <input type="checkbox"/> Comatose 4 <input type="checkbox"/> Depressed 6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other	
14. Prognosis 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent	

Continued

Appendix

ARCHIVAL USE ONLY
 Refer to the Online Handbook for current policy

Prior Authorization Number
1234567

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

RN

1 visit PRN/month x 6 months. To be used for condition changes, such as when blood pressure or glucose becomes unstable and exceeds parameters established for patient.

HHA

2x per week for 2 hours per visit x 3 months. Assist with ADLs, vital signs q visit. Meal planning and preparation of 1800 calorie ADA diet, observe for s/s of low or high blood glucose and report any changes to RN.

Call RN — blood sugar < 60 > 300

SBP > 160 < 100 DBP > 90 < 50

P > 120 < 50

Family members will assist with medications. Daughter will also check blood glucose levels 2 x week and report to the RN.

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for current policy

16. Goals / Rehabilitation Potential / Discharge Plans

Patient will continue to follow 1800 calorie ADA diet and maintain blood glucose within normal limits. Patient will continue to receive assistance with ADLs, bath, meal prep as needed. Patient will progress to her max potential with ADLs and ambulation. Patient will have blood pressure monitored 2 x wk. Patient will continue to receive family support.

Continued

Prior Authorization Number
1234567

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Recipient 04/02/05	18. Dates of Last Inpatient Stay Within 12 Months (If Known) Admission 03/29/05 Discharge 04/02/05	19. Type of Facility for Last Inpatient Stay (If Applicable) A
--	---	--

20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

Pt hospitalized 03/29/05 with hypoglycemia. Also diagnosed with HTN. Placed on new blood pressure medication (Vasotec) and Furosemide. Glucophage dose decreased.

HH aide to monitor vitals and blood glucose, assist with ADLs, meal planning, and preparation.

21. Home or Social Environment

Lives alone in an apartment. Family members care for patient on days not receiving HH aide services.

22. Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home (Include Frequency)

**community center 2 x week
 church weekly**

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 Refer to the Online Handbook
 for current policy

23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

N/A

SECTION VI — SIGNATURES

Nurse Certification

As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate. I am familiar with all information entered on this form. I am responsible for ensuring that the plan of care is carried out as specified. I have received authorization from the attending physician to provide services to the recipient. I have reviewed the information in this document with the attending physician on the date specified. (The date specified refers to the date entered in Element 25 of this form.)

24. SIGNATURE — Authorized Nurse Completing Form I M Nurse	25. Date Reviewed with Attending Physician 04/01/05	26. Date Received Physician-Signed Form 04/02/05
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Physician Certification

The recipient is under my care, and I have authorized the services on this PA/HCA.

27. Name and Address — Attending Physician (Street, City, State, Zip Code)

**IM Physician
 100 Main St
 Anytown, WI 55555**

28. SIGNATURE — Attending Physician I M Physician	29. Date Signed — Attending Physician 04/02/05
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Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

Appendix 6

Sample Prior Authorization/Home Care Attachment (PA/HCA) for Private Duty Nursing Ventilator-Dependent Recipient Services

(A sample copy of the Prior Authorization/Home Care Attachment [PA/HCA] for private duty nursing ventilator-dependent recipient services is located on the following pages.)

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Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
 PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)**

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for detailed information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Prior Authorization Number 1234567	2. Name and Telephone Number — Recipient I.M. Recipient (987) 654-3210
3. Start of Care Date 04/01/05	4. Certification Period From 04/01/05 To 06/01/05

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis) V46.11 Ventilator-dependent, 03/02/05	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses) 31.29 Surgical Procedure — Tracheostomy, 03/02/05 518.81 Respiratory Failure, 03/02/05
--	---

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment
LP6 ventilator, suction machine, ambu bag, concha humidifier

<p>8a. Functional Limitations</p> <p>1 <input type="checkbox"/> Amputation 5 <input checked="" type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind</p> <p>2 <input type="checkbox"/> Bowel / Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance 10 <input type="checkbox"/> Dyspnea with Minimal Exertion</p> <p>3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation 11 <input type="checkbox"/> Other (Specify in Element 8b)</p> <p>4 <input type="checkbox"/> Hearing 8 <input checked="" type="checkbox"/> Speech</p>	8b. If "Other" checked in Element 8a, specify other functional limitations.
<p>9a. Activities Permitted</p> <p>1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing 10 <input checked="" type="checkbox"/> Wheelchair</p> <p>2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent at Home 11 <input type="checkbox"/> Walker</p> <p>3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches 12 <input type="checkbox"/> No Restrictions</p> <p>4 <input type="checkbox"/> Transfer Bed / Chair 9 <input type="checkbox"/> Cane 13 <input type="checkbox"/> Other (Specify in Element 9b)</p> <p>5 <input checked="" type="checkbox"/> Exercises Prescribed</p>	9b. If "Other" checked in Element 9a, specify other activities permitted.

10. Medications (Dose / Frequency / Route)

Vitamin C 500mg daily GT

Bisacodyl suppository 10mg PRN PR (no BM in 3 days)

Neosporin PRN top trach site redness

11. Allergies

Amoxicillin — rash

12. Nutritional Requirements

Pediasure per G-tube QID. Pediasure 100cc bolus to run over 1 hour followed by 60cc H₂O. Vent G-tube PRN abdominal discomfort.

13. Mental Status	1 <input checked="" type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other _____
14. Prognosis	1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input type="checkbox"/> Fair	4 <input checked="" type="checkbox"/> Good
				5 <input type="checkbox"/> Excellent

Appendix

ARCHIVAL USE ONLY
 Refer to the Online Handbook for current policy

Prior Authorization Number
1234567

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

RCS RN/LPN 16hrs/day. Hours may be used flexibly. 1 – 24 hrs a day, 7 days a week, not to exceed 896 hrs in an 8-week period. Care to be provided when parents not available due to work, sleep and family responsibility. Nurse or parent to provide cares while in school.

RCS RN will administer all medications, treatments, and other cares as ordered.
RCS LPB will monitor patient (Pt) status and administer all medications, treatments, and other cares as ordered.

Pt is a full code

RN assesses/LPN monitors: Cardiac, respiratory, GI, GU, neuro, and integumentary systems q shift & PRN.

Vital signs:

TPR q shift and PRN. Reporting parameters: T>101 <95F, AP >100 <60, SBP >158 <100, DBP >90 <60, R see vent. settings.

Respiratory:

LP6 up to 24 hrs/day. Wean from vent. 2hrs BID as Pt tolerates.

Settings: SIMV mode, Tidal Volume: 0.4, Rate: 24, Low Pressure alarm: 8, sensitivity: -1, Cycling Pressure: 0 - 35.

Check settings, internal battery, external battery, alarms, Pt pressures, & in-line temp q shift and PRN.

Humidity: Pt may use Concha system up to 24 hrs/day.

Tracheostomy:

Neonatal Shiley size 3.5. Downsize tube to 3.0 for emergency use. Site care BID & PRN: cleanse with ½ peroxide and ½ H₂O, dry and apply split gauze dressing. Change inner cannula daily and PRN. Trach tie changes PRN. Trach tube changes to be completed by MD.

Suctioning:

Suction with 8fr. Catheter PRN. Manual ventilation PRN. Oral suction PRN. Check suction machine pressure q shift.

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for current policy

16. Goals / Rehabilitation Potential / Discharge Plans

Goals:

Pt will remain free of respiratory distress or infection. Pt's airway will be maintained and kept patent. Pt's G-tube will be maintained and kept patent and free of s/s of infection. Pt will achieve developmental milestones appropriate to age.

Rehab potential: Fair

Discharge:

Discharge will be considered if pt no longer requires trach to maintain airway or parents are able to assume all cares.

Continued

Prior Authorization Number
1234567

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Recipient 03/30/05	18. Dates of Last Inpatient Stay Within 12 Months (If Known) Admission 03/02/05 Discharge 03/30/05	19. Type of Facility for Last Inpatient Stay (If Applicable) A
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20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

Pt hospitalized 03/02/05 for respiratory failure. Tracheostomy performed 03/02/05 and was placed on ventilator for life support 03/02/05. No other complications while hospitalized. Will be discharged home 04/01/05 to parent's and nurse's care. Weaning trails initiated in hospital and will continue when at home.

Pt is awake and alert. Currently pt on vent. Lung sounds clear but diminished in the bases. Bowel sounds active and is tolerating bolus tube feedings. Skin is intact. Vital signs WNL. Voiding and BMs WNL.

21. Home or Social Environment

Patient lives with parents and one school-aged sibling. Both parents work full-time outside of the home.

22. Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home (Include Frequency)

**MD appointments monthly
school 7am — 3pm, 5 days/wk**

23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

**Available back-up personnel include: IM Alternate.
DME provider (IM Dme) will provide 24 hrs/day service for repair and delivery of necessary equipment.**

Ventilator and suction machine have battery back-up. Local electric company, police and EMS have been notified of electrical needs. Emergency procedures for severe weather and fire are posted in the home.

Extra trachs available size 3.0 and 3.5. Ambu bag and face mask readily accessible at all times. Maintain all equipment according to manufacture's recommendation.

Emergency plan in event of accidental extubation.

- 1. Replace the tube using a clean tube.**
- 2. If unable to reinsert tube, occlude stoma and manually ventilate with ambu bag and face mask at usual ventilation rate and activate EMS.**

SECTION VI — SIGNATURES

Nurse Certification
As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate. I am familiar with all information entered on this form. I am responsible for ensuring that the plan of care is carried out as specified. I have received authorization from the attending physician to provide services to the recipient. I have reviewed the information in this document with the attending physician on the date specified. (The date specified refers to the date entered in Element 25 of this form.)

24. SIGNATURE — Authorized Nurse Completing Form I M Nurse	25. Date Reviewed with Attending Physician 03/29/05	26. Date Received Physician-Signed Form 03/30/05
--	---	--

Physician Certification
The recipient is under my care, and I have authorized the services on this PA/HCA.

27. Name and Address — Attending Physician (Street, City, State, Zip Code)

**IM Physician
1234 Oak St
Anytown, WI 55555**

28. SIGNATURE — Attending Physician I M Physician	29. Date Signed — Attending Physician 03/30/05
---	--

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

Appendix

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Appendix 7

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

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

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

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Home Health Therapy Attachment (PA/HHTA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid at the address listed below. If other home health services (e.g., nursing, aide services) are being provided in addition to home health therapy services, complete this attachment form and submit it with the appropriate forms for the other services. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

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for current policy

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

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

Element 2 — Age — Recipient

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

Element 3 — Recipient Medicaid Identification Number

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

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist

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

Element 5 — Therapist's Medicaid Provider Number

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

Element 6 — Telephone Number — Therapist

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

Element 7 — Name — Referring/Prescribing Physician

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

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

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

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

SECTION III — DOCUMENTATION

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

Element 9

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

Element 10

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

Element 11

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

Element 12

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

Element 13

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

Element 14

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

Element 15

Describe rehabilitation potential.

Element 16 — Signature — Requesting Provider

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

Element 17 — Date Signed

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

Other Required Information

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

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Appendix 8

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

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

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

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

SECTION I — RECIPIENT INFORMATION

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

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist

5. Therapist's Medicaid Provider Number

6. Telephone Number — Therapist

7. Name — Referring / Prescribing Physician

8. Referring / Prescribing Physician's Medicaid Provider Number

SECTION III — DOCUMENTATION

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

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

SECTION III — DOCUMENTATION (Continued)

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

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

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

ARCHIVAL USE ONLY

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

Refer to the Online Handbook
for current policy

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

15. Describe Rehabilitation Potential

16. **SIGNATURE** — Requesting Provider

17. Date Signed

Appendix 9

Sample Prior Authorization/Home Health Therapy Attachment (PA/HHTA)

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

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

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

SECTION I — RECIPIENT INFORMATION

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

Recipient, Ima A.

2. Age — Recipient

67

3. Recipient Medicaid Identification Number

1234567890

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist

I.M. Performing, P.T.

5. Therapist's Medicaid Provider Number

87654321

6. Telephone Number — Therapist

(123) 456-7890

7. Name — Referring / Prescribing Physician

I.M. Referring

8. Referring / Prescribing Physician's Medicaid Provider Number

12345678

SECTION III — DOCUMENTATION

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

Recipient admitted to hospital 04/15/05 after CVA with residual left hemiparesis. Discharged home on 05/01/05 at insistence of wife. Nursing home placement unacceptable to family. Prior to CVA, recipient was independent in ADL and active around the house, in the community, and with his grandchildren. Recipient did have low endurance and fatigue due to COPD.

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

Recipient hospitalization complicated by pneumonia. Recipient has history of long standing COPD and arteriosclerosis. In 2000 he had mitral valve replacement and double bypass surgery. In 2001 he had L radical neck resection. Recipient alert, feels frightened, exhibits poor safety awareness, and unsteady when ambulating.

Continued

SECTION III — DOCUMENTATION (Continued)

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

Service Area	Location	Date	Problem Treated
Physical Therapy	Hospital	04/18/05 to 4/30/05	Hemiplegia — therapeutic exercise, ROM, balance activities, ADL
	Home	05/01/05 to present	
Occupational Therapy	Hospital	04/18/05 to 4/30/05	Hemiplegia — motor skills
	Home	05/01/05 to present	
Speech and Language Pathology	Hospital	04/18/05 to 4/30/05	Dysphagia
	Home	05/01/05 to present	

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

ROM, MMT, ADL, Gait — 5/1/05. AAROM WNL all extremities, except as follows: R shoulder, Flex 0-130, ABD 0-120, IR 0-50; L shoulder flex 120, ABD 0-110, IR 0-30, BILAT Knees — 5 extension, transfers — moderate assist of one. Recipient has excessive trunk extension, ground weight bearing R LE, minimal weight bearing on LLE. Recipient requires min-moderate assist to complete all bed mobility. Moderate assist to ambulate for 100 feet times 3 with wheeled walker. Recipient becomes short of breath, has poor balance and excessive trunk extension.

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 for current policy

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

Recipient remains as above. Recipient has active movements in all L LE joints. Movements independent, but with mild extensor tone in LLE and mild flexor tone in LUE. Supervision to minimal assist to complete pivot transfers. Recipient demonstrates proper technique and weight shifting from sit to stand: but continues to have excessive trunk extension from stand to sit. Recipient independent in bed mobility with tactile cueing. Good unsupported, unchallenged sitting balance. Recipient able to ambulate 200 feet with wheeled walker and supervision of one for occasional loss of balance backwards. Gait does exhibit decreased weight shift to L, minimal flexion in L LE decreased step length on R, decreased floor clearance with increased retraction L. hip.

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

See attached plan of care.

15. Describe Rehabilitation Potential

Excellent. Recipient has made excellent progress in the past month with 3X week therapy. He is well motivated and cooperates with therapy program. Anticipate recipient will be independent in ADL and gait if no complications occur and PT continues with home health aid carry through.

16. SIGNATURE — Requesting Provider

I M Performing P.T.

17. Date Signed

06/06/05

Appendix 10

Prior Authorization Request Form (PA/RF) Completion Instructions for Home Care 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), HCF 11018, 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 listed in Appendix 17 of this handbook, by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

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

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for current policy

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Note: Wisconsin Medicaid accepts PA requests with a maximum of 12 details per PA number. The Wisconsin Medicaid PA/RF has space for five items. If a provider's PA request requires more than five items to be listed, the provider may continue the PA request on a second and third PA/RF. When submitting a PA request with multiple pages, indicate the page number and total number of pages for the PA/RF in the upper right hand corner (e.g., "page 1 of 2" and "page 2 of 2"). On the form(s) used for page 2 and, if appropriate, page 3, cross out the seven-digit PA number and write the PA number from the first form. Refer to instructions for Elements 16 and 22 for more information.

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Appendix 10 (Continued)

Element 3 — Processing Type

Enter processing type “120” for home health/home health therapy. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 4 — Billing Provider’s Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

Enter the recipient’s 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient’s Medicaid identification card or the Medicaid 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 Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date

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

Element 15 — Performing Provider Number (not required)

Appendix 10 (Continued)

Element 16 — Procedure Code

Enter the appropriate *Current Procedural Terminology* (CPT) code or Healthcare Common Procedure Coding System (HCPCS) procedure code for each service/procedure requested.

Note: If the provider needs additional spaces for Elements 16-21 for the PA request, the provider may complete additional PA/RF(s). The provider needs to cross out the preprinted PA number on the additional PA/RFs and write in the preprinted PA number from the first PA/RF. The PA/RFs should be identified, for example, as “page 1 of 2” and “page 2 of 2.”

Element 17 — Modifiers

Enter modifiers, if appropriate, for the procedure code as listed in Appendix 19 of this handbook. Do not list start-of-shift modifiers.

Element 18 — POS

Enter the appropriate place of service (POS) code(s) designating where the requested service/procedure would be provided/performed. Refer to Appendix 20 of this handbook for a list of allowable POS codes.

Element 19 — Description of Service

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

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

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

If sharing a case with another provider, enter “shared case” and include a statement that the total number of hours of all providers will not exceed the combined total number of hours ordered on the physician’s plan of care (POC). When requesting two procedure codes to be used interchangeably, include a statement that the total number of hours will not exceed the combined total number of hours ordered on the physician’s POC. When requesting permission to bill for multiple visits when only one visit is provided, enter “Authorization requested to bill for (number of) subsequent Home Health Aide visits to do (number of) continuous hours of care.”

Element 20 — QR

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

Element 21 — Charge

Enter the usual and customary charge for each service/procedure requested. If the quantity is greater than “1.0,” multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider’s usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the provider *Terms of Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request. If the provider completed a multiple-page PA/RF, the total charges should be indicated on Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 should refer to the last page (for example, “see page two.”)

Appendix 10 (Continued)

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting this service/procedure must appear in this element.

Element 24 — Date Signed

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

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

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Appendix 11

Sample Prior Authorization Request Form (PA/RF) for Home Health Skilled Nursing and Home Health Aide Services

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.

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

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

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION						
10. Diagnosis — Primary Code and Description 250.00 — Diabetes II (NIDDM)	11. Start Date — SOI MM/DD/YY	12. First Date of Treatment — SOI MM/DD/YY				
13. Diagnosis — Secondary Code and Description 401.9 — Hypertension NOS	14. Requested Start Date MM/DD/YY					
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4	18. POS	19. Description of Service	20. QR	21. Charge
	99600		12	HHN — initial visit 1 visit/day x 3 days/wk x 29 weeks	87	XXX.XX
	T1021		12	HHA — initial visit 1 visit/day x 7 days/week x 29 weeks	203	XXX.XX
	99600	TS	12	HHN — follow-up visit 1 visit/day x 3 days/wk x 29 weeks	87	XXX.XX
	T1021	TS	12	HHA — follow-up visit 1 visit/day x 7 days/week x 29 weeks	203	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

23. SIGNATURE — Requesting Provider <div style="text-align: center; font-size: 2em;">I M Provider</div>	24. Date Signed MM/DD/YY
---	------------------------------------

FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved <div style="display: flex; justify-content: space-around; margin-top: 10px;"> _____ Grant Date _____ Expiration Date </div> <input type="checkbox"/> Modified — Reason: <input type="checkbox"/> Denied — Reason: <input type="checkbox"/> Returned — Reason:		
SIGNATURE — Consultant / Analyst _____		Date Signed _____

Appendix

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Refer to the Online Handbook
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Appendix 12

Sample Prior Authorization Request Form (PA/RF) for Home Health Skilled Nursing Requesting Pro Re Nata Visits

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.

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

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

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION									
10. Diagnosis — Primary Code and Description 250.00 — Diabetes II (NIDDM type)					11. Start Date — SOI			12. First Date of Treatment — SOI	
13. Diagnosis — Secondary Code and Description 401.9 — Hypertension NOS					14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
	1 2 3 4								
	99600				12		HHN - initial visit, 1 visit/day x 3 days/wk x 3 wks	12 visits	XXX.XX
							3 PRN visits/month x 1 month		

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

23. SIGNATURE — Requesting Provider <div style="font-size: 2em; text-align: center;">I M Provider</div>	24. Date Signed MM/DD/YY
--	--

FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Grant Date Expiration Date </div>		
<input type="checkbox"/> Modified — Reason: _____		
<input type="checkbox"/> Denied — Reason: _____		
<input type="checkbox"/> Returned — Reason: _____		
_____ SIGNATURE — Consultant / Analyst		_____ Date Signed

Appendix

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Appendix 13

Sample Prior Authorization Request Form (PA/RF) for Private Duty Nursing Ventilator-Dependent Recipient Services

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.

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

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION							
10. Diagnosis — Primary Code and Description V46.11 — Ventilator	11. Start Date — SOI MM/DD/YY	12. First Date of Treatment — SOI MM/DD/YY					
13. Diagnosis — Secondary Code and Description 344.0 — Quadriplegia		14. Requested Start Date MM/DD/YY					
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4	18. POS	19. Description of Service	20. QR	21. Charge	
	99504	TD		12, 99	RCS-HH/RN 12°/d, 7d/wk x 53 wk	4,452 hrs	XX,XXX.XX
	99504	TE		12, 99	RCS-HH/LPN 12°/d, 7d/wk x 53 wk	4,452 hrs	XX,XXX.XX
				Shared case with independent nurses. Total hours for all providers will not exceed total hours on POC.			
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,XXX.XX	

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

FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved <div style="text-align: center; margin-top: 10px;"> _____ Grant Date Expiration Date </div> <input type="checkbox"/> Modified — Reason: <input type="checkbox"/> Denied — Reason: <input type="checkbox"/> Returned — Reason:		
_____ SIGNATURE — Consultant / Analyst		_____ Date Signed

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Appendix 14

Sample Prior Authorization Request Form (PA/RF) for Home Health Therapy Services

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

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

SECTION I — PROVIDER INFORMATION

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

SECTION II — RECIPIENT INFORMATION

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description 429.2 — CVA					11. Start Date — SOI		12. First Date of Treatment — SOI		
13. Diagnosis — Secondary Code and Description 250.00 — Diabetes II (NIDDM)					14. Requested Start Date MM/DD/YY				
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
	97799	1	2	3	4	12	HH-physical therapy 1 visit/day x 3 days/wk x 26wks	78 visits	X,XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

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

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

- Approved
- _____ Grant Date _____ Expiration Date
- Modified — Reason:
- Denied — Reason:
- Returned — Reason:

SIGNATURE — Consultant / Analyst Date Signed

Appendix

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Appendix 15
Prior Authorization Amendment Request Completion Instructions
(for photocopying)

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(A copy of the Prior Authorization Amendment Request Completion Instructions is located on the following pages.)
Refer to the Online Handbook
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WISCONSIN MEDICAID PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Amendment Request to the Prior Authorization Request Form (PA/RF) and physician's orders (within 90 days of the dated signature) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

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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 — RECIPIENT INFORMATION

Element 1 — Today's Date

Enter today's date in MM/DD/YYYY format.

Element 2 — Previous PA Number

Enter the seven-digit PA request number from the PA/RF to be amended. The request number is located in the top right section of the PA/RF.

Element 3 — Name — Recipient

Enter the recipient's name as indicated in Element 8 on the PA/RF, including recipient's last and first name and middle initial.

Element 4 — Recipient Medicaid Identification No.

Enter the ten-digit recipient Medicaid identification number as indicated in Element 5 on the PA/RF.

SECTION II — PROVIDER INFORMATION

Element 5 — Name — Billing Provider

Enter the billing provider's name as indicated in Element 1 of the PA/RF.

Element 6 — Billing Provider's Medicaid Provider No.

Enter the eight-digit billing provider's Medicaid provider number as indicated in Element 4 on the PA/RF.

Element 7 — Address — Billing Provider

Enter the billing provider's address (include street, city, state, and Zip code) as indicated in Element 1 of the PA/RF.

Element 8 — Amendment Effective Dates

Enter the dates that the requested amendment should start and end.

SECTION III — AMENDMENT INFORMATION

Element 9

Enter the reasons for requesting additional service(s) for the recipient.

Element 10

Enter the appropriate procedure code and hours per day, days per week, multiplied by the number of weeks for each service.

Element 11 — Signature — Requesting Provider

Enter the signature of the provider requesting this amendment.

Element 12 — Date Signed

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

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Appendix 16
Prior Authorization Amendment Request
(for photocopying)

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(A copy of the Prior Authorization Amendment Request is located on the following page.)
Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST**

Providers may submit prior authorization (PA) amendment requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization Amendment Request Completion Instructions (HCF 11042A).

SECTION I — RECIPIENT INFORMATION

1. Today's Date	2. Previous PA Number
3. Name — Recipient (Last, First, Middle Initial)	4. Recipient Medicaid Identification No.

SECTION II — PROVIDER INFORMATION

5. Name — Billing Provider	6. Billing Provider's Medicaid Provider No.
7. Address — Billing Provider (Street, City, State, Zip Code)	8. Amendment Effective Dates

SECTION III — AMENDMENT INFORMATION

9. List reasons for amendment request.

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10. Indicate procedure(s) to be amended by hours per day, days per week, multiplied by the number of weeks.

Registered Nurse _____

Licensed Practical Nurse _____

Home Health Aide _____

Physical Therapist _____

Occupational Therapist _____

Speech-Language Pathologist _____

Personal Care Worker _____

Other _____

11. **SIGNATURE** — Requesting Provider

12. Date Signed

Appendix 17

Prior Authorization Forms Required for Home Health Services

The following table contains a complete listing of the prior authorization (PA) forms required by Wisconsin Medicaid for each of the following types of home health services when providers are requesting PA for that service.

Home Care Service Type	Prior Authorization Forms Required by Wisconsin Medicaid
Home Health Skilled Nursing	<ul style="list-style-type: none"> • Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 10/03). • Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096 (09/05) OR the recipient's plan of care (POC) in another format that contains <i>all</i> of the components requested in the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A (09/05).
Home Health Aide	<ul style="list-style-type: none"> • PA/RF. • PA/HCA OR the recipient's POC in another format that contains <i>all</i> of the components requested in the PA/HCA Completion Instructions.
Private Duty Nursing	<ul style="list-style-type: none"> • PA/RF. • PA/HCA OR the recipient's POC in another format that contains <i>all</i> of the components requested in the PA/HCA Completion Instructions. • Private Duty Nursing Prior Authorization Acknowledgment, HCF 11041 (Rev. 09/05).
Private Duty Nursing for Ventilator-Dependent Recipients	<ul style="list-style-type: none"> • PA/RF. • PA/HCA OR the recipient's POC in another format that contains <i>all</i> of the components requested in the PA/HCA Completion Instructions. • Private Duty Nursing Prior Authorization Acknowledgment.
Home Health Therapy	<ul style="list-style-type: none"> • PA/RF. • Prior Authorization Home Health Therapy Attachment (PA/HHTA), HCF 11044 (Rev. 06/03). • Therapy POC. • Therapy evaluation. • Individualized Family Service Plan (for children under three years of age). • Individualized Education Plan (for school-aged children between three and 21 years of age).

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Appendix 18

National Uniform Billing Code Revenue Codes for Home Health Services

Providers will be required to use the appropriate revenue codes on the UB-92 claim form for home health services. The codes listed below are examples of codes that might be used.

Code	Service Description
0550	General Skilled Nursing
0551	Skilled Nursing Visit
0552	Skilled Nursing Hourly Charge
0580	Other Home Health Services, Except Therapies
0420	Physical Therapy
0430	Occupational Therapy
0440	Speech and Language Pathology

For the most current and complete list of revenue codes, contact the American Hospital Association National Uniform Billing Committee (NUBC) by calling (312) 422-3390 or writing to the following address:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606

For more information, refer to the NUBC Web site at www.nubc.org/.

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Appendix 19

Procedure Codes and Modifiers for Home Health Services

The following table lists allowable procedure codes and modifiers that home health agencies are required to use when submitting claims for home health services.

Procedure Code and Description (Limited to Medicaid Covered Service)	National Modifier	State-Defined Start-of-Shift Modifier
90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use	None	None
90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use	None	None
90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use	None	None
92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual [per visit]	None	UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)
97139 Unlisted therapeutic procedure (specify) [per visit]	None	UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)

**Appendix 19
(Continued)**

Procedure Code and Description (Limited to Medicaid Covered Service)	National Modifier	State-Defined Start-of-Shift Modifier
<p align="center">97799 Unlisted physical medicine/rehabilitation service or procedure [per visit]</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">99504 Home visit for mechanical ventilation care [per hour]</p>	<p align="center">TE LPN/LVN*</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">99504 Home visit for mechanical ventilation care [per hour]</p>	<p align="center">TD RN**</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">99600 Unlisted home visit service or procedure [per visit]</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">99600 Unlisted home visit service or procedure [per visit]</p>	<p align="center">TS Follow-up service</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">S9123 Nursing care, in the home; by registered nurse, per hour</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>

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**Appendix 19
(Continued)**

Procedure Code and Description (Limited to Medicaid Covered Service)	National Modifier	State-Defined Start-of-Shift Modifier
<p align="center">S9124 Nursing care, in the home; by licensed practical nurse, per hour</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">T1001 Nursing assessment/evaluation [per visit]</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">T1021 Home health aide or certified nurse assistant, per visit</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">T1021 Home health aide or certified nurse assistant, per visit</p>	<p align="center">TS Follow-up service</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>
<p align="center">T1502 Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit</p>	<p align="center">None</p>	<p align="center">UJ Night (12 a.m. to 5:59 a.m.) UF Morning (6 a.m. to 11:59 a.m.) UG Afternoon (12 p.m. to 5:59 p.m.) UH Evening (6 p.m. to 11:59 p.m.)</p>

* LPN/LVN = Licensed Practical Nurse/Licensed Vocational Nurse.

** RN = Registered Nurse.

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Appendix 20

Allowable Place of Service Codes for Home Health Services

The following table lists the nationally recognized two-digit place of service codes that providers are required to use when submitting prior authorization requests for home health services.

Place of Service Code	Description
03	School
12	Home
99	Other Place of Service

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Appendix 21

Rounding Guidelines for Home Health Services

The total number of services (hours) billed for each detail line on the UB-92 claim form must be listed in Form Locator 46 of the UB-92 claim form. Home health services are rounded and billed in half-hour increments. If the visit is over 30 minutes in length, round up or down to the nearest 30-minute increment, using the common rule of rounding shown in the following table.

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

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Appendix 22

UB-92 (CMS 1450) Claim Form Completion Instructions for Home Health Services

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

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by calling (312) 422-3390 or writing to the following address:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606

For more information, go to the NUBC Web site at www.nubc.org/.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid 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 Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

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

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — Unlabeled Field (not required)

Form Locator 3 — Patient Control No. (optional)

The provider may enter the patient's internal office account number. This number will appear on the Medicaid remittance information.

Appendix 22 (Continued)

Form Locator 4 — Type of Bill

Enter the three-digit code indicating the specific type of claim. The first digit identifies the type of facility. The second digit classifies the type of care. Providers of home care services are required to bill type “33X.” The third digit (“X”) indicates the billing frequency and should be assigned as follows:

- 1 = Inpatient admit through discharge claim.
- 2 = Interim bill — first claim.
- 3 = Interim bill — continuing claim.
- 4 = Interim bill — final claim.

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Cov D. (not required)

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (not required)

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name

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

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src (not required)

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Appendix 22 (Continued)

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

Form Locator 23 — Medical Record No. (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the Medicaid remittance information.

Form Locators 24-30 — Condition Codes (required, if applicable)

If appropriate, enter a code to identify conditions relating to this claim that may affect payer processing. Refer to the UB-92 Uniform Billing Manual for a list of condition codes.

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the UB-92 Uniform Billing Manual for codes.

Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code for the procedure code indicated in Form Locator 44. Enter revenue code "0001" on the line with the sum of all the charges. Refer to the UB-92 Billing Manual for codes.

Form Locator 43 — Description

Enter the date of service (DOS) in the MMDDYY format either in this form locator or in Form Locator 45.

When series billing (i.e., billing from two to four DOS on the same line), indicate the DOS in the following format: MMDDYY, MMDD, MMDD, MMDD. Indicate the dates in order of occurrence from the first to the last of the month.

Providers may enter up to four DOS for each revenue and procedure code if all the following conditions are met:

- All DOS are in the same calendar month.
- All DOS are listed in order of occurrence from the first to the last of the month.
- All procedure codes are identical.
- All procedure modifiers are identical.
- All charges are identical.
- All quantities billed for each DOS are identical.

Appendix 22 (Continued)

If billing a range of dates for the rental of durable medical equipment, the range of dates must be within a single calendar month and indicated in the following manner: MMDDYY–MMDDYY. On paper claims, no more than 23 lines may be submitted on a single claim, including the “total charges” line.

Note: Wisconsin Medicaid encourages providers to enter only one DOS per line. Although series billing (entering multiple DOS on the same line) remains an option, providers may find that meeting the conditions limits the convenience of utilizing this method.

Form Locator 44 — HCPCS/Rates

Enter the appropriate five-digit procedure code, followed by as many as four modifiers. Separate the procedure code and the modifier(s) with commas.

Form Locator 45 — Serv. Date

Enter the DOS in the MMDDYY format either in this item or in Form Locator 43. Do not indicate multiple DOS in this form locator. Multiple DOS are required to be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of covered accommodations, ancillary units of service, or visits, where appropriate. Bill even hours or half-hour increments rounded to the nearest half hour. Refer to Appendix 21 of this handbook for rounding guidelines for procedure codes in which one unit equals one hour.

Form Locator 47 — Total Charges

Enter the usual and customary charges pertaining to the related procedure code for the current billing period as entered in Form Locators 43 or 45. Enter revenue code “0001” to report the sum of all charges in Form Locator 47.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer

Enter all health insurance payers here. For example, enter “T19” for Wisconsin Medicaid and/or the name of commercial health insurance.

Form Locator 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Form Locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C & P — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter “000.” Do *not* enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due (not required)

Appendix 22 (Continued)

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured's Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (required, if applicable)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF), HCF 11018. Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Form Locator 64 A-C — ESC (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.

Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition that is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis.

Form Locators 68-75 — Other Diag. Codes

Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received. Diagnoses that relate to an earlier episode and that have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis.

Form Locator 76 — Adm. Diag. Cd. (not required)

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Appendix 22 (Continued)

Form Locator 80 — Principal Procedure Code and Date (not required)

Form Locator 81 — Other Procedure Code and Date (not required)

Form Locator 82 a-b — Attending Phys. ID

Enter the name and the Unique Physician Identification Number, eight-digit Wisconsin Medicaid provider number, or license number.

Form Locator 83 a-b — Other Phys. ID (not required)

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial health insurance billing information

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

When the recipient has dental (“DEN”) insurance only or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, *and* the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes *must* be indicated in the *first* line of Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient’s commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

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

Medicare information

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

Appendix 22 (Continued)

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

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

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

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

Form Locator 85 — Provider Representative

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

Note: The signature may be a computer-printed or typed name or a signature stamp.

Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

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Appendix 23

Sample UB-92 Claim Form for Home Health Skilled Nursing and Home Health Aide Services

IM BILLING PROVIDER 1 W. WILSON ANYTOWN, WI 55555 (555) 321-1234		2		3 PATIENT CONTROL NO. JED 1234		31 TYPE OF BILL 332	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH		7 COV D	8 N-C-D	9 C-I-D
12 PATIENT NAME RECIPIENT, IM A.				13 PATIENT ADDRESS			
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR
22 STAT		23 MEDICAL RECORD NO. 03 765432		24 CONDITION CODES 01			
32 OCCURRENCE DATE	34 OCCURRENCE DATE	36 OCCURRENCE SPAN FROM THROUGH		37			
38		39 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42	
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0550	MMDYY	99600 UF		1.0	XXX XX		
2							
3 0001	TOTAL CHARGES				XXX XX		
4							
5							
6							
7							
8							
9							
10							
11							
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14							
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18							
19							
20							
21							
22							
23							
50 PAYER MEDICARE XYZ INSURANCE T19 MEDICAID		51 PROVIDER NO. 87654321	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS XX XX	55 EST AMOUNT DUE	56
57		DUE FROM PATIENT					
58 INSURED'S NAME		59 P.REL	60 CERT. - SSN - HIC - ID NO. 1234567890	61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES 1234567		64 ESC	65 EMPLOYER NAME		66 EMPLOYER LOCATION		
67 PRIN. DIAG CD 436	68 CODE	69 CODE	OTHER DIAG. CODES 72 CODE		74 CODE	75 ADM. DIAG. CD	77 E-CODE
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	82 ATTENDING PHYS. ID 12345678 I.M. ATTENDING		83 OTHER PHYS. ID		
84 REMARKS M-7 OI-P		85 PROVIDER REPRESENTATIVE X I M B. Provider		86 DATE MMDYY			

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Appendix 24

Sample UB-92 Claim Form for Private Duty Nursing Services Including Shifts Spanning Midnight

IM BILLING PROVIDER 1 W. WILLIAMS ANYTOWN, WI 55555 (555) 321-1234		2		3 PATIENT CONTROL NO. 12345ABCD		4 TYPE OF BILL 333	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH		7 COV D	8 N-C-D	9 C-I-D
12 PATIENT NAME RECIPIENT, IM A.				13 PATIENT ADDRESS			
14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR
				22 STAT		23 MEDICAL RECORD NO. 03 7654321	
32 OCCURRENCE DATE		34 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37	
						A B C	
				39 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
				a		a	
				b		b	
				c		c	
				d		d	
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1 0550	120103	S9123 UH			4.0	XXX XX	
2 0550	120203	S9123 UJ, UH			8.0	XXX XX	
3 0550	120303	S9123 UJ			4.0	XXX XX	
4							
5 0001	TOTAL CHARGES					XXXX XX	
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
50 PAYER T19 MEDICAID		51 PROVIDER NO. 87654321		52 REL INFO	53 ASB BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE
				DUE FROM PATIENT ▶			
58 INSURED'S NAME		59 P.REL	60 CERT. - SSN - HIC. - ID NO. 1234567890		61 GROUP NAME		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES 1234567		64 ESC	65 EMPLOYER NAME		66 EMPLOYER LOCATION		
67 PRIN DIAG CD	68 CODE	70 CODE	OTHER DIAG. CODES 72 CODE		74 CODE	76 ADM. DIAG. CD	77 E-CODE
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID 12345678 I.M. ATTENDING		83 OTHER PHYS. ID	
84 REMARKS				85 PROVIDER REPRESENTATIVE X I M B. Provider		86 DATE MMDDYY	

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Appendix 25

Sample UB-92 Claim Form for Private Duty Nursing Ventilator-Dependent Recipient Services

APPROVED OMB NO. 0938-0279

IM BILLING PROVIDER 1 W. WILLIAMS ANYTOWN, WI 55555 (555) 321-1234				2		3 PATIENT CONTROL NO. 12345ABCD		4 TYPE OF BILL 333																											
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV D		8 N-C-D																									
12 PATIENT NAME RECIPIENT, IM A.				13 PATIENT ADDRESS																															
14 BIRTHDATE		15 SEX		16 MS		17 DATE		18 HR		19 TYPE 1		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO. 03 7654321		24		25		26		27		28		29		30		31	
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38		39 VALUE CODES CODE		40 VALUE CODES AMOUNT		41 VALUE CODES CODE		42 VALUE CODES AMOUNT															
42 REV. CD.				43 DESCRIPTION				44 HCPCS / RATES				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49															
1 0550				MMDDYY				99504 TD, UG						9.5		XXX XX																			
2 0550				MMDDYY				99504 TD, UG						9.5		XXX XX																			
3 0550				MMDDYY				99504 TD, UG						6.0		XXX XX																			
4 0550				MMDDYY, MMDD, MMDD, MMDD				99504 TD, UG						24.0		XXX XX																			
5 0001				TOTAL CHARGES										XXXX XX																					
6																																			
7																																			
8																																			
9																																			
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11																																			
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22																																			
23																																			
A T19 MEDICAID				51 PROVIDER NO. 87654321				52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST AMOUNT DUE		56																			
B				C DUE FROM PATIENT																															
A				58 INSURED'S NAME				59 P.REL		60 CERT. - SSN - HIC - ID NO. 1234567890		61 GROUP NAME		62 INSURANCE GROUP NO.																					
B				C																															
A				63 TREATMENT AUTHORIZATION CODES 1234567				64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION																							
B				C																															
67 PRIN DIAG CD V4611		68 CODE		69 CODE		OTHER DIAG. CODES 70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 ADM DIAG CD		76 E-CODE		77															
79 P.C.		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID 12345678 I.M. ATTENDING		83 OTHER PHYS. ID		84 REMARKS		85 PROVIDER REPRESENTATIVE X IM B. Provider		86 DATE MMDDYY																					
a		b		c		d		e		f		g																							

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Appendix 26

Sample UB-92 Claim Form for Home Health Therapy Services

IM BILLING PROVIDER 1 W. WILSON ANYTOWN, WI 55555 (555) 321-1234		2		3 PATIENT CONTROL NO. JED 1234		4 TYPE OF BILL 332												
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 COV D.	8 N-C-D	9 C-I-D.	10 L-R-D.	11										
12 PATIENT NAME RECIPIENT, IM A.				13 PATIENT ADDRESS														
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO. 03 7654321	24	25 CONDITION CODES		26	27	28	29	30	31
32 OCCURRENCE DATE	33	34 OCCURRENCE DATE	35	36 OCCURRENCE SPAN FROM	37	38	39	40	41	42	43	44	45	46	47	48	49	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49				
1 0420		MMDDYY		97799 UF				1.0		XXX XX								
3 0001		TOTAL CHARGES								XXX XX								
50 PAYER MEDICARE XYZ INSURANCE T19 MEDICAID				51 PROVIDER NO. 87654321		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS XX XX		55 EST AMOUNT DUE		56						
DUE FROM PATIENT																		
58 INSURED'S NAME				59 P.REL.				60 CERT. - SSN - HIC. - ID NO. 1234567890				61 GROUP NAME		62 INSURANCE GROUP NO.				
63 TREATMENT AUTHORIZATION CODES 1234567				64 ESC.				65 EMPLOYER NAME				66 EMPLOYER LOCATION						
67 PRIN DIAG CD 436		68 CODE		70 CODE		OTHER DIAG. CODES 72 CODE		74 CODE		76 ADM DIAG. CD		77 E-CODE		78				
79 P.C		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID 12345678 I.M. ATTENDING		83 OTHER PHYS. ID		84 REMARKS M-7 OI-P		85 PROVIDER REPRESENTATIVE X IM B. Provider		86 DATE MMDDYY				

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Appendix 27

Adult Immunization Record

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(A copy of the Adult Immunization Record is located on the following page.)
Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
ADULT IMMUNIZATION RECORD**

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. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. This form can be used to let the doctor know what immunizations the recipient has received. If the recipient has received his or her influenza or pneumococcal immunization at a clinic other than where his or her doctor practices, the recipient may give this form to his or her doctor for notification.

Name — Recipient (Last, First, Middle Initial)			Date of Birth — Recipient (MM/DD/YYYY)	
	Type of Vaccine	Date Administered (MM/DD/YYYY)	Name — Health Professional or Clinic Administering Vaccine	Address and Telephone Number — Health Professional or Clinic
	Influenza			
	Pneumococcal			

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Name — Recipient (Last, First, Middle Initial)			Date of Birth — Recipient (MM/DD/YYYY)	
	Type of Vaccine	Date Administered (MM/DD/YYYY)	Name — Health Professional or Clinic Administering Vaccine	Address and Telephone Number — Health Professional or Clinic
	Influenza			
	Pneumococcal			

Appendix 28

Disposable Medical Supplies Included in Home Care Reimbursement Rate

For the most current list of disposable medical supplies (DMS) included in the home care reimbursement rate, refer to the DMS Index on the Wisconsin Medicaid Web site at dhfs.wisconsin.gov/medicaid/. A paper copy of the DMS Index can be downloaded from the Wisconsin Medicaid Web site or ordered by calling Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Disposable medical supplies included in the home care reimbursement rate include, but are not limited to, those listed in the following table.

Procedure Code	Modifier	Description
A4244	—	Alcohol per pint
A4365	—	Adhesive remover wipes, any type, per 50 (Ostomy use only)
A4402	—	Lubricant per ounce
A4455	—	Adhesive remover or solvent (for tape, cement, or other adhesive) per ounce
A4554	—	Disposable underpads, all sizes [when used for purposes <i>other than</i> incontinence or bowel and bladder programs]
A4927	—	Gloves, non-sterile, per 100
A4626	59	Applicators
A4626	22	Cotton balls per 100

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