

Nurse Midwife Services

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Nurse midwives use this handbook in conjunction with the Physician Services Handbook.
Nurse midwives Medicaid certified as nurse practitioners should use the Nurse Practitioner Services Handbook.

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883 (Madison area)	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720 (Madison area)	7:30 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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P Preface

The Wisconsin Medicaid and BadgerCare Nurse Midwife Services Handbook is issued to non-master's level nurse midwives (Medicaid certified as nurses in independent practice). It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare. Nurse midwives who are Medicaid certified as nurse practitioners should use the Nurse Practitioner Services Handbook.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

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

Verifying Recipient Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

Nurse midwives are issued the Nurse Midwife Services Handbook and the Physician Services Handbook.

Nurse midwives use this handbook in conjunction with the Physician Services Handbook. The Physician Services Handbook consists of the following sections:

- Medicine and Surgery.
- Laboratory and Radiology.
- Anesthesia.

Each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

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

Legal Framework of Wisconsin Medicaid and BadgerCare

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

Federal Law and Regulation

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

Wisconsin Law and Regulation

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

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

Handbooks and *Updates* organized by provider type, maximum allowable fee schedules, helpful telephone numbers and addresses, Remittance and Status messages, and much more information about Wisconsin

Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

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

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General Information

Nurse midwives should use this handbook in conjunction with the Physician Services Handbook. The Nurse Midwife Services Handbook includes the following limited information that applies to fee-for-service Medicaid-certified nurse midwives:

- Covered services, including obstetric services.
- Protocols and collaborative agreements.
- Provider eligibility and certification.
- Provider numbers.
- Reimbursement.

Nurse midwives should refer to the Physician Services Handbook for the following information:

- Billing and reimbursement.
- Evaluation and management services.
- Health Personnel Shortage Areas.
- Laboratory services.
- Medicine services.
- Radiology services.
- Surgery services.

The Physician Services Handbook also contains the following forms for nurse midwife use:

- Breast Pump Order form.
- Newborn Report form.
- Provider Certification of Emergency for Undocumented Aliens form (for photocopying).
- Specialized Medical Vehicle Transportation Physician Certification form (for photocopying).

Provider Eligibility and Certification

Nurse Midwife Certification

Nurse midwives who treat Medicaid recipients are required to be Medicaid certified to receive Medicaid reimbursement. This applies to nurse midwives whose services are reimbursed under a physician's or clinic's Medicaid provider number, as well as to those who independently submit claims to Wisconsin Medicaid.

A Master's degree-prepared nurse midwife is eligible to be Medicaid certified as a nurse practitioner. Medicaid-certified nurse practitioners have a broader range of Medicaid-allowable services for which they may be reimbursed and receive higher reimbursement. Nurse midwives Medicaid-certified as nurse practitioners should use the Nurse Practitioner Services Handbook.

Nurse midwives who are not educated at the Master's degree prepared are Medicaid certified as nurses in independent practice with a specialty of nurse midwife.

To be reimbursed by Wisconsin Medicaid, a nurse midwife must be certified under HFS 105.201, Wis. Admin. Code. A nurse midwife must also be a professional nurse currently licensed by the Board of Nursing pursuant to s. 441, Wis. Stats., and certified as a nurse midwife pursuant to s. 441.15, Wis. Stats.

Medicaid services performed by nurse midwives must be within the legal scope of practice as defined under the Wisconsin Board of Nursing licensure or certification. Services performed must be included in the individual nurse midwife's protocols or a collaborative

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relationship with a physician as defined by the Board of Nursing.

Pursuant to Board of Nursing Ch. N 8.10(7), Wis. Admin. Code, advanced practice nurse prescribers work in a collaborative relationship with a physician. (The collaborative relationship means an advanced practice nurse prescriber works with a physician, “in each other’s presence when necessary, to deliver health care services within the scope of the practitioner’s professional expertise.”)

Advanced practice nurse prescribers who dispense drugs in addition to prescribing them should obtain the appropriate Medicaid pharmacy publications. The Medicaid Web site (www.dhfs.state.wi.us/medicaid/) contains a list of all published materials for each Medicaid provider type and many of the publications may be downloaded. Providers may also call Provider Services at (800) 947-9627 or (608) 221-9883 if Internet access is not available.

Medicaid-certified nurse midwives who are not advanced practice nurse prescribers practice in collaboration with a physician with postgraduate training in obstetrics and pursuant to a written agreement with that physician, pursuant to the Board of Nursing s. 441.15, Wis. Stats. Collaboration is defined here to mean “a process that involves two or more health care professionals working together and, when necessary, in each other’s presence, and in which each health care professional contributes his or her expertise to provide more comprehensive care than one health care professional alone can offer.”

Protocols/Collaborative Agreements

Pursuant to Board of Nursing Ch. N 8.10(7), Wis. Admin. Code, advanced practice nurse prescribers work in a collaborative relationship with a physician. (The collaborative relationship means an advanced practice nurse prescriber works with a physician, “in each other’s presence when necessary, to deliver

health care services within the scope of the practitioner’s professional expertise.”) The advanced nurse prescriber and the physician must document this relationship.

Medicaid-certified nurse midwives who are not advanced practice nurse prescribers practice in collaboration with a physician with postgraduate training in obstetrics and pursuant to a written agreement with that physician, pursuant to Wisconsin statute for the Board of Nursing, chapter 441.15. Collaboration is defined here to mean “a process that involves two or more health care professionals working together and, when necessary, in each other’s presence, and in which each health care professional contributes his or her expertise to provide more comprehensive care than one health care professional alone can offer.”

For purposes of Medicaid reimbursement, no service which is a medical act and is listed in this handbook or Physician Services Handbook may be performed without a collaborative agreement as required for advanced practice nurse prescribers (pursuant to N 8.10 Wis. Admin. Code) or nurse midwives (pursuant to s. 441.15), or protocols, written or verbal orders for registered nurses (pursuant to N 6.03, Wis. Admin. Code).

Provider Numbers

Wisconsin Medicaid issues all providers, whether individuals, agencies, or institutions, an eight-digit provider number to bill Wisconsin Medicaid for services provided to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for a Medicaid-certified provider to bill using a provider number belonging to another Medicaid-certified provider.

A provider keeps the same provider number in the event that he or she relocates, changes specialties, or voluntarily withdraws from Wisconsin Medicaid and later chooses to be reinstated. (Notify Provider Maintenance of changes in location or of specialty by using the

Medicaid-certified nurse midwives who are not advanced practice nurse prescribers practice in collaboration with a physician with postgraduate training in obstetrics and pursuant to the Board of Nursing s. 441.15, Wis. Stats.

Wisconsin Medicaid Provider Change of Address or Status Form, which may be found in the September 2002 *Wisconsin Medicaid and BadgerCare Update (2002-52)*, titled “Two All-Provider Handbook forms revised.” The *Update* and form are available on the Medicaid Web site at www.dhfs.state.wi.us/medicaid/.) A provider’s number is not reissued to another provider in the event of termination from Wisconsin Medicaid.

Wisconsin Medicaid reimburses nurse midwife services under two types of provider numbers. Each type of provider number has its designated uses and restrictions. The two types are:

- Billing/performing provider number.
- Group billing number.

Billing/Performing Provider Number (Issued to Nurse Midwives)

Wisconsin Medicaid issues a billing/performing provider number to nurse midwives that allows them to identify themselves on the CMS 1500 claim form as either the biller of services or the performer of services when a clinic or group is billing for the services.

Nurse Midwives Who Submit Claims to Wisconsin Medicaid as Performing Providers Through a Physician or Clinic

Nurse midwives who submit claims to Wisconsin Medicaid as performing providers are required to indicate their own provider number in Element 24K of the CMS 1500 claim form. The billing provider number of the physician or clinic must be indicated in Element 33.

Nurse Midwives Who Independently Submit Claims to Wisconsin Medicaid

Nurse midwives who directly submit claims to Wisconsin Medicaid for services must indicate their provider number in Element 33 of the CMS 1500 claim form as the billing provider. It is not necessary to indicate a provider number in Element 24K.

Group Billing Number (Issued to Clinics)

Two or more nurse midwives can be issued a group billing number which is primarily an accounting convenience. A clinic or group using a group billing number receives one reimbursement and one Remittance and Status (R/S) Report for covered services performed by individual providers within the clinic or group.

Individual providers within a clinic or group must also be Medicaid certified because clinics and groups are required to identify the performer of the service on the claim form. (The performing provider’s Medicaid provider number must be indicated in Element 24K of the CMS 1500 claim form when a group billing number is indicated in Element 33.) Ordinarily, a claim billed with only a group billing number is denied reimbursement. Refer to the CMS 1500 claim form completion instructions in the Physician Services Handbook for more information.

Medicaid-Covered Nurse Midwife Services

Nurse midwives are limited to providing the following categories of Medicaid-covered services:

- Family planning services.
- Laboratory services.
- Obstetric services.
- Office and outpatient visits.
- Tuberculosis (TB)-related services.

The practice of nurse midwifery means the management of women’s health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse Midwives and the education, training, and experience of the nurse midwife (Board of Nursing s. 441.15, Wis. Stats.).

Nurse midwives are limited to providing the following categories of Medicaid-covered services:

- Family planning services.
- Laboratory services.
- Obstetric services.
- Office and outpatient visits.
- Tuberculosis (TB)-related services.

Nurse midwives should refer to Appendix 1 of this handbook for a list of allowable procedure codes for nurse midwives and Appendix 2 for a list of allowable local procedure codes.

Appendix 3 lists the allowable Medicaid-covered type of service (TOS) and place of service (POS) codes for nurse midwives.

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

All nurse midwife services must be fully documented in the recipient's medical record and available for inspection or review by Medicaid auditors.

Refer to HFS 107.03, Wis. Admin. Code, for services *not covered* by Wisconsin Medicaid. Refer to the Covered and Noncovered Services section of the All-Provider Handbook for a partial list of the noncovered services.

Reimbursement for Nurse Midwives

Maximum Allowable Fees

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

Wisconsin Medicaid reimburses nurse midwives 100% of the physician maximum allowable fee for laboratory services and injections and 90% of the physician maximum allowable fee for other physician services. Nurse midwives are required to use the appropriate TOS and POS codes as listed in Appendix 3 of this handbook.

Nurse midwives may obtain a copy of the Nurse Midwife Services Maximum Allowable Fee Schedule from one of the following sources:

- An electronic version on Wisconsin Medicaid's Web site at www.dhfs.state.wi.us/medicaid/.
- Purchase a paper copy by writing to:

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

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

Enhanced Reimbursement

Wisconsin Medicaid provides an enhanced reimbursement rate for the following services:

- *Health Professional Shortage Areas (HPSAs)*. Wisconsin Medicaid provides enhanced reimbursement to providers when one or both of the following apply:
 - ✓ The performing or billing provider is located in a HPSA-eligible ZIP code.
 - ✓ The recipient has a residential address (according to Medicaid's eligibility records) within a HPSA-eligible ZIP code. (*Note:* Nurse midwives receive a 20% incentive payment for HPSA-related primary care services and a 50% incentive bonus for HPSA-eligible obstetric services, when the above criteria are met.)
- *Pediatric services*. Wisconsin Medicaid provides enhanced reimbursement for office and other outpatient services and emergency department services for recipients 18 years of age and under.

Refer to the Medicine and Surgery section of the Physician Services Handbook for more information about these enhanced reimbursement.

Nurse midwives should refer to Appendix 1 of this handbook for a list of allowable procedure codes for nurse midwives and Appendix 2 for a list of allowable local procedure codes.

Obstetric Services

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery.

Wisconsin Medicaid offers providers choices of how and when to file claims for obstetric (OB) care. Providers may choose to submit claims using either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the date of service (DOS).

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery. The exception to this rule is in the case of multiple births, where more than one delivery may be reimbursed (see “Delivery” section for details).

Separate Obstetric Care Components

Providers should use the following guidelines when submitting claims for separate OB components.

Antepartum Care

Antepartum care includes dipstick urinalysis, routine exams and recording of weight, blood pressure, and fetal heart tones.

Providers should refer to the table on this page as a guide for submitting claims for a specific number of antepartum care visits. Providers should provide all antepartum care visits before submitting a claim to Wisconsin Medicaid.

Providers should use local procedure codes W6000 — “antepartum care; initial visit” — and W6001 — “antepartum care; two or three visits” — when submitting claims for the first

through third antepartum care visits with a provider or provider group. For example, if a total of two to three antepartum care visits is performed, the provider should indicate procedure code W6000 and a quantity of “1.0” for the first DOS. For the second and third visits, the provider should indicate procedure code W6001 and a quantity of “1.0” or “2.0,” as indicated in the table. The date of the last antepartum care visit is the DOS.

Note: Do not use evaluation and management procedure codes when submitting claims for the first three antepartum care visits. Use of these codes may result in improper reimbursement.

Similarly, for *Current Procedural Terminology* (CPT) codes 59425 — “antepartum care only; 4-6 visits” — and 59426 — “antepartum care only; 7 or more visits” — the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed “1.0.”

Antepartum Care Claims Submission Guide			
Total Visit(s)	Procedure Code*	Description	Quantity
1	W6000	Antepartum care; initial visit	1.0
2	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	1.0
3	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	2.0
4-6	59425	Antepartum care only; 4-6 visits	1.0
7+	59426	7 or more visits	1.0
*Nurse midwives should submit claims with types of service (TOS) "9" for these codes.			

Occasionally, a provider may be unsure of whether a recipient has had previous antepartum care visits with another provider. If the recipient is unable to provide this information, the provider should assume the first time he or she sees the recipient is the first antepartum visit.

Note: Reimbursement for procedure codes W6000, W6001, 59425, and 59426 is limited to once per pregnancy, per recipient, per billing provider. A telephone call between patients and providers does not qualify as an antepartum visit.

Delivery

Delivery includes patient preparation, placement of fetal heart or uterine monitors, insertion of catheters, delivery of the child and placenta, injections of local anesthesia, induction of labor, and artificial rupture of membranes.

Providers who perform deliveries may submit claims using the appropriate delivery codes. A clinic or group may submit claims for the delivery component separately and should indicate the provider who performed the delivery as the performing provider, rather than the primary OB provider.

When there are multiple deliveries (e.g., twins, triplets), providers should submit one claim for all of the deliveries. On the first detail line of the CMS 1500 claim form, indicate the appropriate procedure code for the first delivery. Indicate additional births on separate detail lines of the claim form, using the appropriate delivery procedure code for each delivery.

Wisconsin Medicaid does not recognize modifiers “-51” or “-22.”

Induction of Labor

Wisconsin Medicaid covers induction of labor only when the service is documented in the recipient’s medical record and when performed on a date other than the delivery

date. Providers should submit claims for this service with CPT procedure code 59899 — “Unlisted procedure, maternity care and delivery” — with supporting documentation attached to the claim.

Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

Wisconsin Medicaid reimbursement for postpartum care includes hospital *and* office visits following delivery. In accordance with the standards of the American College of Obstetricians and Gynecologists, postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting claims for postpartum care, the DOS is the date of the post-hospital discharge office visit. In order to receive reimbursement, the recipient *must* be seen in the office. The length of time between a delivery and the office postpartum visit should be dictated by good medical practice. Wisconsin Medicaid does not dictate an “appropriate” period for postpartum care; however, the industry standard is six to eight weeks following delivery. A telephone call between patients and providers does *not* qualify as a postpartum visit.

Delivery and Postpartum Care

Providers who perform both the delivery and postpartum care may use either the separate delivery and postpartum codes or the delivery including postpartum care CPT procedure codes 59410, 59515, 59614, or 59622, as appropriate. The DOS for the combination codes is the delivery date. However, if the

Wisconsin Medicaid covers induction of labor only when the service is documented in the recipient’s medical record and when performed on a date other than the delivery date.

recipient fails to return for the postpartum visit, the provider must adjust the claim to reflect delivery only or the reimbursement will be recouped through audit.

Global Obstetric Care

Providers may submit claims using global OB codes. Providers choosing to submit claims for global OB care must perform all of the following:

- A minimum of six antepartum visits.
- Delivery.
- The post-delivery hospital visit and a minimum of one postpartum office or home visit.

When submitting claims for global OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS.

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global OB care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider must adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the patient's medical record. (Refer to the section on postpartum care.)

Group Claims Submission for Global Obstetric Care

When several OB providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and

postpartum care to the same recipient during the period of pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. When submitting the claims, providers should indicate the group Medicaid billing number and identify the primary OB provider as the performing provider.

Emergency Deliveries

Emergency deliveries that are performed outside either an inpatient hospital setting or the patient's home are covered if documentation (i.e., history, physical examination, or summaries) attached to the paper claim supports the procedure's urgent or emergent nature. Nurse midwives should call Provider Services at (800) 947-9627 or (608) 221-9883 for deliveries performed outside of an inpatient hospital setting or a recipient's home. Claims for these situations are special handled.

Home Deliveries

Wisconsin Medicaid allows certified nurse midwives to perform maternity care and delivery in a recipient's home (place of service [POS] "4").

Refer to Appendix 4 of this handbook for a list of allowable maternity care and delivery procedure codes allowed in POS "4."

Separately Covered Pregnancy-Related Services

Services that may be reimbursed separately from the global or component obstetrical services include:

- Administration of RH immune globulin.
- Amniocentesis, chorionic villous sampling, and cordocentesis.
- Epidural anesthesia. (Refer to the Physician Services Handbook for epidural anesthesia claims submission information.)
- External cephalic version.
- Fetal biophysical profiles.

When submitting claims for global OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS.

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- Fetal blood scalp sampling.
- Fetal contraction stress and non-stress tests.
- Harvesting and storage of cord blood.
- Insertion of cervical dilator.
- Laboratory tests, excluding dipstick urinalysis.
- Obstetrical ultrasound and fetal echocardiography.
- Sterilization. (Refer to the Physician Services Handbook for sterilization limitations.)
- Surgical complications of pregnancy (e.g., incompetent cervix, hernia repair, ovarian cyst, Bartholin cyst, ruptured uterus, or appendicitis).

Extraordinary Circumstances With Pregnancy and/or Delivery

Providers treating recipients whose pregnancies require more than the typical number of antepartum visits or result in complications during delivery may seek additional reimbursement by initially submitting and being reimbursed for a claim for OB services. Providers are required to then submit an Adjustment Request Form that includes a copy of the medical record and/or delivery report specifying the medical reasons for the extraordinary number of antepartum or postpartum visits. A medical consultant will review the materials and determine the appropriate level of reimbursement.

Wisconsin Medicaid does not recognize the “-22” modifier.

Complications of Pregnancy

If a nurse midwife encounters a situation during delivery which requires the assistance of a physician, the physician performing the

delivery must bill for the delivery. The nurse midwife may be reimbursed for his or her service by submitting a paper claim using the CPT procedure code 99499 (unlisted evaluation and management services) in addition to any antepartum and postpartum care provided. Documentation on the medical necessity of the services provided must be submitted with the claim. Reimbursement is determined by the Medicaid medical consultant.

Unrelated Conditions

Any evaluation and management services performed that are related to the pregnancy are included in reimbursement for obstetrical care. However, conditions unrelated to the pregnancy may be separately reimbursed by Wisconsin Medicaid. These include, but are not limited to:

- Chronic hypertension.
- Diabetes.
- Management of cardiac, neurological, or pulmonary problems.
- Other conditions (e.g., urinary tract infections) with a diagnosis other than complication of pregnancy.

Health Professional Shortage Area Incentive Reimbursement

All OB procedure codes are eligible for the Health Professional Shortage Area (HPSA) incentive reimbursement. Submit claims indicating the appropriate HPSA modifier “HP” or “HK” to receive a 50% bonus incentive. Refer to the Billing and Reimbursement chapter of the Medicine and Surgery section of the Physician Services Handbook for further information.

All OB procedure codes are eligible for the Health Professional Shortage Area (HPSA) incentive reimbursement.

Services Provided Prior to Wisconsin Medicaid Eligibility

Wisconsin Medicaid will reimburse the equivalent of one global OB fee per recipient, per delivery, per single provider or provider group, whether the reimbursement is made through fee-for-service or through a Medicaid managed care program.

Wisconsin Medicaid OB payments apply only to services provided while the person is eligible as a Medicaid recipient. Services provided prior to Wisconsin Medicaid eligibility are not included in the number of antepartum visits, the delivery, or postpartum care.

Fee-for-Service Recipients Subsequently Enrolled in a Medicaid Managed Care Program

Wisconsin Medicaid will reimburse the equivalent of one global OB fee per recipient, per delivery, per single provider or provider group, whether the reimbursement is made through fee-for-service or through a Medicaid managed care program.

When a recipient who is initially eligible for fee-for-service Medicaid enrolls in a Medicaid managed care program during her pregnancy, and receives care from the same provider or

clinic when eligible for Medicaid fee-for-service and when enrolled in a managed care program, her provider may be paid a global fee by the managed care program after fee-for-service has paid for antepartum care. The provider is then required to submit an adjustment(s) to have fee-for-service Medicaid payment recouped.

If the provider does not submit the adjustment(s) in this situation, Wisconsin Medicaid will recoup the fee-for-service payment(s) through audit. If the recipient receives less than global OB care while enrolled in the Medicaid managed care program, Wisconsin Medicaid reimburses her provider no more than the global maximum allowable fee or the sum of the individual components for services. Wisconsin Medicaid will, on audit, recoup any amount paid under fee-for-service that is above the global fee or the combined maximum allowable fee for the services if billed separately.

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Newborn Care

Newborn Reporting

Providers are required to promptly report newborns born to fee-for-service Medicaid recipients to Wisconsin Medicaid. Establishing a newborn's Medicaid eligibility results in better health outcomes and fewer delays in provider reimbursement. Refer to Appendix 6 of this section for a Wisconsin Medicaid Newborn Report form for photocopying. Providers may also obtain the Newborn Report from the forms section of the Medicaid Web site at www.dhfs.state.wi.us/medicaid.

Providers Required to Report Newborns

Hospitals, Medicaid HMOs, physicians, nurse practitioners, and nurse midwives may report newborns born to Medicaid recipients by submitting a Wisconsin Medicaid Newborn Report, or another form developed by the provider that contains all the same information, to Wisconsin Medicaid.

Physicians, nurse practitioners, and nurse midwives should *only* complete a Newborn Report if the recipient is not enrolled in an HMO and the birth occurs outside a hospital setting. Otherwise, the Medicaid HMO or hospital should complete the form.

Newborn Report Submission

Providers have the option of sending newborn reports in a summary format on a weekly basis to Wisconsin Medicaid or individual reports for each newborn. However, the summary report must contain all the information provided in the Newborn Report.

If possible, the Newborn Report form should be submitted to Wisconsin Medicaid with the child's given name (first and last name), rather than "baby boy" or "baby girl" as the first name. The four-digit year should be included when reporting the child's date of birth. (To

report a child's date of death, the two- or four-digit year format may be used.) Wisconsin Medicaid still requires providers to submit a Newborn Report in instances in which the baby is born alive, but does not survive.

Submit the Newborn Report form to Wisconsin Medicaid by mail or fax:

Wisconsin Medicaid
PO Box 6470
Madison WI 53716
Fax: (608) 224-6318

This information on newborn reporting pertains to the birth of a newborn to a Medicaid recipient who is not enrolled in an HMO.

Recipients Enrolled in Medicaid HMOs

Under the Medicaid managed care contract, HMOs are required to report to Wisconsin Medicaid the birth of a newborn to a mother enrolled in an HMO. Because of this requirement, hospitals and HMOs should coordinate the newborn reporting function to prevent duplicate reporting by the hospital and HMO of the same newborn. Following these procedures assures more timely reimbursement for services provided to infants.

Newborn Report Procedures

Once the completed Newborn Report is submitted to Wisconsin Medicaid, the following procedures take place:

- A pseudo (temporary) Medicaid identification number is assigned to the newborn, regardless of whether the newborn is named (if Medicaid eligibility is not yet on file).
- A Medicaid Forward card is created for the child and sent to the mother as soon as the child's eligibility is put on file.

Providers are required to promptly report newborns born to fee-for-service Medicaid recipients to Wisconsin Medicaid.

- Wisconsin Medicaid sends a letter to the mother, notifying her of the child's eligibility. The letter also contains a statement that the mother is required to sign, stating that the baby has continued to live with her since birth. She must send this statement to her county or tribal eligibility worker in the envelope provided and is required to tell her eligibility worker that she has a new baby with a temporary Medicaid identification number.
- A copy of this letter is also sent to the county economic support agency.
- Once the mother notifies her worker and her child has received a Social Security number, a permanent Medicaid number is assigned to the child.
- The provider receives a copy of the eligibility notification letter sent to the child's mother as confirmation.

Providers with questions regarding newborn eligibility may contact Provider Services at (800) 947-9627 or (608) 221-9883.

Newborn Screenings

Providers are required to test newborns for certain congenital and metabolic disorders, per s. 253.13, Wis. Stats. These tests require a prepaid filter paper card purchased from the State Laboratory of Hygiene. Wisconsin Medicaid reimburses providers for purchasing the prepaid filter paper cards and the laboratory handling fee for newborn screenings performed outside a hospital setting.

Coverage and Reimbursement Procedures

The following is a list of the CPT codes with allowable POS and/or TOS codes and instructions for submitting claims to Wisconsin Medicaid for Medicaid-covered newborn screening services.

- 86849 — Unlisted immunology procedure.
 - ✓ Wisconsin Medicaid reimburses this procedure code for prepaid filter paper cards purchased from the State Laboratory of Hygiene.

- ✓ This procedure code is allowable in POS "3" (doctor's office) or POS "4" (home) for TOS "5" (diagnostic laboratory — total charge).
- ✓ In Element 19 of the CMS 1500 claim form enter "Newborn screening state lab card" or attach documentation to a paper claim to indicate the claim is for a prepaid filter paper card for newborn screening purchased from the Wisconsin State Laboratory of Hygiene.

- 99000 — Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory.
 - ✓ Wisconsin Medicaid reimburses this procedure code for the transfer of the specimen from the physician's office to the State Laboratory of Hygiene.
 - ✓ Certified nurse midwives who are not Medicaid certified as nurse practitioners use TOS "9" (other) for this procedure code.
 - ✓ Nurse midwives must check the "outside lab" box "Yes" (Element 20 on CMS 1500 claim form).
 - ✓ Indicate a quantity of 1.0 since the specimen is going to only one lab.

- 99001 — Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory.
 - ✓ Wisconsin Medicaid covers this procedure code for the transfer of the specimen from a location other than a physician's office to the State Laboratory of Hygiene.
 - ✓ Certified nurse midwives who are not certified as nurse practitioners use TOS "9" (other) for this procedure code.
 - ✓ Nurse midwives must check the "outside lab" box "Yes" (Element 20 on CMS 1500 claim form).
 - ✓ Indicate a quantity of 1.0 since the specimen is going to only one lab.

Providers with questions regarding newborn eligibility may contact Provider Services at (800) 947-9627 or (608) 221-9883.

A Appendix

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Appendix 1

Wisconsin Medicaid-Allowable Procedure Codes for Certified Nurse Midwives

The following chart is periodically revised. Refer to Appendix 3 of this handbook for applicable type of service (TOS) codes and descriptions.

<i>Current Procedural Terminology (CPT) Procedure Codes</i>		
Service	Code(s)	Type of Service
Insertion, implantable contraceptive capsules	11975	2
Removal, implantable contraceptive capsules	11976	2
Removal with reinsertion, implantable contraceptive capsules	11977	2
Intrauterine Device — Female Genital System	58300-58301	2
Maternity Care and Delivery	59025, 59300, 59400-59430, 59610-59614, W6000-W6001	9
	59400-59410, 59514, 59610-59614	8
Diagnostic Ultrasound	76816	4
	76819	4, Q, U
Urinalysis	81001-81003	5
Chemistry	82565, 82950, 84132, 84295, 84450, 84520, 84550, 84703	5
Hematology and Coagulation	85018, 85025, 85027	5
Immunology	86592, 86703, 86762	5
Unlisted Immunology Procedure	86849 (Newborn screening card)	5
Transfusion Medicine	86850, 86900	5
Microbiology	87070, 87081, 87210, 87340, 87491, 87880	5
Cytopathology	88164	5
Immune Globulins	90384	1
Therapeutic or Diagnostic Infusions	90780-90781	1
Therapeutic, Prophylactic or Diagnostic Injections	90782	9
Special Services, Procedures and Reports	99000-99001	9
	99070	1
Evaluation and Management	99201-99215	9
Prolonged Services*	99354*-99355*	9
Newborn Care	99432	9
	99436	1
	99440	9
Unlisted Evaluation and Management Service	99499	9
Preventive Medicine	99381, 99391	9

*This procedure code must be submitted on a HCFA 1500 claim form with documentation attached to the claim showing medical necessity. This code should be billed by a certified nurse midwife (CNM) only in place of service "4" (home) when the CNM attends the labor of a patient and subsequently admits the patient to the hospital for the birth.

Healthcare Common Procedure Coding System (HCPCS) Procedure Codes		
Service	Code	Type of Service
Injection, ampicillin sodium/sulbactam sodium, per 1.5 gram	J0295	1
Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	J1055	9
Injection, methylergonovine maleate, [Methergine Maleate], up to 0.2 mg	J2210	1
Injection, oxytetracycline HCl, up to 50 mg	J2460	1
Injection, RHo(D) immune globulin, human, [Rhogam], one dose package	J2790	1
Injection, phytonadione (vitamin K), per 1 mg	J3430	1
Intrauterine copper contraceptive	J7300	1
Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7302	1

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Appendix 2

Wisconsin Medicaid-Allowable Local Procedure Codes for Nurse Midwives

The following chart is periodically revised. Refer to Appendix 3 of this handbook for applicable type of service codes and descriptions.

Procedure Code	Description	Type of Service
Maternity Care		
W6000	Antepartum care; initial visit	9
W6001	two or three visits	9

Family Planning Services		
W6200	Intrauterine device — progesterone	1
W6201	Diaphragm	9
W6202	Jellies, creams, foams	9
W6203	Suppositories	9
W6204	Sponges (per 1)	9
W6205	Condoms (per 1)	9
W6206	Natural family planning supplies	9
W6207	Oral contraceptives	9
W6208	Female condom	9
W6209	Cervical cap	9
W6210	Family planning pharmaceutical visit; includes oral contraceptives	9
W6211	initial visit, non-comprehensive	9
W6212	annual visit, non-comprehensive	9

Tuberculosis (TB)-Related Procedures		
W6271	Directly observed preventive therapy — TB-infected only	1
W6272	Monitoring of TB symptoms — TB-infected only	1
W6273	Patient education and anticipatory guidance — TB-infected only	1
W6274	Direct observation of therapy — suspect or confirmed active TB case	1
W6275	Monitoring of TB symptoms — suspect or confirmed active TB case	1
W6276	Patient education and anticipatory guidance — suspect or confirmed active TB case	1

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Appendix 3

Wisconsin Medicaid-Allowable Type of Service and Place of Service Codes

Type of Service	Description
1	Medical care, injections, HealthCheck (EPSDT)
2	Surgery
4	Diagnostic X-ray (total charge)/Ultrasound (total charge)
5	Diagnostic lab (total charge) HealthCheck lab
8	Assistant surgery
9	Other

Place of Service	Description
0	Other
1	Inpatient hospital
2	Outpatient hospital
3	Office
4	Home

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Appendix 4

Wisconsin Medicaid-Allowable Procedure Codes Covered in Place of Service "4" — Recipient's Home

Procedure Code	Description	Type of Service
59300	Episiotomy or vaginal repair, by other than attending physician	9
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care	8, 9
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	8, 9
59410	including postpartum care	8, 9
59414	Delivery of placenta (separate procedure)	9
59425	Antepartum care only; 4-6 visits	9
59426	7 or more visits	9
59430	Postpartum care only (separate procedure)	9
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery	8, 9
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	8, 9
59614	including postpartum care	8, 9
90384	Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use	1
90780	Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour	1
90781	each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)	1
90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	1
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	1, 2
99354*	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)	9
99355*	each additional 30 minutes (list separately in addition to code for prolonged physician service)	9
99440	Newborn resuscitation; provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	9

*This procedure code must be submitted on a HCFA 1500 claim form with documentation attached to the claim showing medical necessity. This code should be billed by a certified nurse midwife (CNM) only in place of service "4" (home) when the CNM attends the labor of a patient and subsequently admits the patient to the hospital for the birth.

Procedure Code	Description	Type of Service
J0295	Injection, ampicillin sodium/sulbactam sodium, per 1.5 gram	1
J2210	Injection, methylergonovine maleate, [Methergine Maleate], up to 0.2 mg	1
J2460	Injection, oxytetracycline HC1, up to 50 mg	1
J3430	Injection, phytonadione (vitamin K), per 1 mg	1
W6000	Antepartum care; initial visit	9
W6001	two or three visits	9

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Appendix 5

Sample CMS 1500 Claim Form — Nurse Midwife Services (Antepartum Care and Delivery Including Postpartum Care With Health Professional Shortage Area Modifier)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.			3. PATIENT'S BIRTH DATE MM DD YY M F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) 609 Willow St			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)							
CITY Anytown		STATE WI	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE				
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS)			a. INSURED'S DATE OF BIRTH MM DD YY M F		b. EMPLOYER'S NAME OR SCHOOL NAME				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F			b. AUTO ACCIDENT?			b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. L 659.80			23. PRIOR AUTHORIZATION NUMBER			24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE						
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. 1234JED			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ XXX XX		30. BALANCE DUE \$ XXX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Nurse Midwife 1 W. Williams Anytown, WI 55555 87654321 PIN# _____ GRP# _____						

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

PLEASE PRINT OR TYPE

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

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Appendix 6
Wisconsin Medicaid Newborn Report
(for photocopying)

(A copy of the Wisconsin Medicaid Newborn Report is located on the following page.)

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WISCONSIN MEDICAID NEWBORN REPORT

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 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 on this form.

INSTRUCTIONS

1. Type or print clearly.
2. All requested information must be provided.
3. In multiple birth situations, a separate Newborn Report must be filled out for each birth.
4. For more information on newborn reporting, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883. Mail or fax completed forms to:

Wisconsin Medicaid
Managed Care
PO Box 6470
Madison WI 53716
Fax (608) 224-6318

SECTION I — HOSPITAL (OR OTHER PROVIDER) INFORMATION

Name — Hospital (or Other Provider)	Wisconsin Medicaid Provider Number (eight digits)
Name — Contact Person	Telephone Number — Contact Person ()

SECTION II — NEWBORN INFORMATION

Name — Newborn (First, Middle Initial, Last)	Date of Birth (MM/DD/YYYY)
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Death, if applicable (MM/DD/YYYY)
Multiple Births <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete a form for each birth.	

SECTION III — MOTHER INFORMATION

Name — Mother	Address (Street Address, City, State, and Zip Code)
Medicaid Identification Number — Mother	
Medicaid Identification Number — Case Head	

SECTION IV — AUTHORIZATION

This information is accurate to the best of my knowledge.	
SIGNATURE — Hospital (or Other Provider) Representative	Date Signed

Glossary of Common Terms

Advanced Practice Nurse Prescriber

An advanced practice nurse prescriber (APNP) is a registered nurse with advanced training and with additional certification by the Board of Nursing and who is able to order diagnostic procedures and issue prescription orders. Advanced practice nurse prescribers work in a collaborative relationship with a physician as defined by the Board of Nursing Chapter N 8.10, Wis. Admin. Code.

BadgerCare

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

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

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services, CMS administers Medicare, Medicaid, related quality assurance programs and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Collaboration

Collaboration for advanced practice nurse prescribers means a process that involves two or more health care professionals working together and, when necessary, in each other's presence, and in which each health care professional contributes his or her expertise to provide more comprehensive care than one health care professional alone can offer. (Board of Nursing Chapter N 8.10, Wis. Admin. Code.)

CPT

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

CRNA

Certified registered nurse anesthetists. A nurse with advanced training in the selection and administration of anesthesia agents and the provision of anesthesia care, who operates independently or under the medical direction of an anesthesiologist, based on standard medical practice.

DHCF

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

DHFS

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

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Glossary (Continued)

DHHS

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

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

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EVS

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

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

Fee-for-service

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

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

HCPCS

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

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

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

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

Glossary (Continued)

Medically necessary

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

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

Nurse Midwife

The practice of nurse midwifery means the management of women's health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse Midwives and the education, training, and experience of the nurse midwife. (Board of Nursing s. 441.15, Stats.)

Nurse Practitioner

A nurse practitioner is a registered nurse with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team.

Medicaid-certified nurse practitioners who work under the general supervision of a physician are required to be supervised only to the extent required pursuant to Board of Nursing Chapter N 6.02(7), Wis. Admin. Code. (Chapter N 6 defines general supervision as the regular coordination, direction, and inspection of the practice of another and does *not* require the physician to be on site.)

On-site supervision

The supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention.

POS

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

R/S Report

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

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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