

Physician Services

Medicine and Surgery

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

C 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 Physician Services Handbook is issued to all Medicaid-certified physician 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

This Physician Services Handbook consists of the following sections:

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

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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General Information

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in HFS 105, Wis. Admin. Code.

The Medicine and Surgery section of the Physician Services Handbook includes information for physician services providers (i.e., physicians, physician assistants, nurse practitioners, and nurse midwives) performing evaluation and management (E&M), medicine, and surgery services. It also includes information about covered services, prior authorization (PA) requirements, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers.

It is essential that providers refer to the All-Provider Handbook for general information about certification, provider rights, documentation requirements, PA, claims submission, and other ongoing responsibilities.

Certification

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in HFS 105, Wis. Admin. Code. Providers may refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for general information about certification.

Physician services providers who perform other services not mentioned in this handbook may refer to the Medicaid Web site or call Provider Services at (800) 947-9627 or (608) 221-9883 to obtain certification packets and more information about coverage limitations for other areas. All information on the Medicaid Web site may be downloaded.

Physicians and Residents

To be certified by Wisconsin Medicaid, physicians and residents are required to be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

Physicians are asked to identify their practice specialty at the time of Medicaid certification. Reimbursement for certain services is limited to physicians with specific specialties.

To be reimbursed for psychiatric services (*Current Procedural Terminology* [CPT] codes 90801-90857, 90865-90899), physicians are required to be certified as a psychiatrist pursuant to HFS 105.22(1)(a), Wis. Admin. Code. Any Medicaid-certified physician may be reimbursed for substance abuse services.

Physician Assistants

To be Medicaid-certified, physician assistants are required to be licensed and registered pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 8 and 14, Wis. Admin. Code. All physician assistants are required to be individually certified by Wisconsin Medicaid for their services to be reimbursed.

Physician assistants cannot independently submit claims to Wisconsin Medicaid. Claims for services provided by a physician assistant must be submitted with the physician assistant's nonbilling performing provider number and the supervising physician's billing provider number.

Nurse Practitioners

Nurse practitioners should refer to the Nurse Practitioner Services Handbook for more information about certification requirements.

Nurse Midwives

Nurse midwives should refer to the Nurse Midwife Services Handbook for more information about certification requirements.

HealthCheck Certification

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and

Treatment (EPSDT) (see 42 CFR Parts 441.56 - 441.62). HealthCheck consists of a comprehensive health screening of Wisconsin Medicaid recipients under age 21. The screening includes review of growth and development, identification of potential physical or developmental problems, preventive health education, and referral assistance to appropriate providers.

Physicians who are Wisconsin Medicaid certified with a specialty of family practice, general practice, internal medicine, or pediatrics and nurse practitioners with specialties of certified pediatric nurse practitioner and certified family nurse practitioner are automatically certified as HealthCheck screeners at the time of initial Medicaid certification and recertification. Providers (physicians and nurse practitioners with other specialties and physician assistants) who are interested in becoming HealthCheck screeners may refer to the Medicaid Web site or call Provider Services.

Presumptive Eligibility for Pregnant Women Benefit

Physicians, physician assistants, nurse practitioners, and nurse midwives may become Medicaid-certified presumptive eligibility (PE) providers. Presumptive Eligibility for Pregnant Women Benefit providers determine whether a pregnant woman may be eligible for Wisconsin Medicaid. The PE for Pregnant Women Benefit is a limited benefit category that allows an uninsured or underinsured (i.e., insured without prenatal coverage) pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit Medicaid is processed. Refer to the Guide to Determining Presumptive Eligibility for Pregnant Women Benefit for more information.

Providers interested in becoming certified to make PE for pregnant women determinations may refer to the Medicaid Web site or call Provider Services.

Presumptive Eligibility for the Family Planning Waiver Program

Providers qualified to make PE decisions for pregnant women may also make PE decisions for women to receive routine contraceptive-related services and supplies immediately through PE for the Family Planning Waiver Program (FPWP) for up to three months. Services and supplies covered under PE for the FPWP are the same as those covered under the FPWP and must be clearly related to routine contraceptive management.

Refer to the Provider section of the Medicaid Web site for more information about the FPWP. Providers interested in becoming certified to make PE for the FPWP determinations may refer to the Medicaid Web site or call Provider Services.

Prenatal Care Coordination Certification

Prenatal care coordination (PNCC) services help pregnant women who are identified as being at high risk for negative birth outcomes gain access to, coordinate, and follow up on necessary medical, social, educational, and other services. Providers interested in becoming PNCC providers may refer to the Medicaid Web site or call Provider Services.

Durable Medical Equipment

To be reimbursed for dispensing durable medical equipment, physicians are required to obtain separate Medicaid certification as a medical equipment vendor. Physicians are required to comply with all federal laws and regulations, including the Stark statute on referrals. Providers interested in becoming Medicaid-certified medical equipment vendors may refer to the Medicaid Web site or call Provider Services.

Provider Numbers

Wisconsin Medicaid issues billing performing, group, and nonbilling performing provider numbers to physician services providers. Refer to the Certification and Ongoing

Wisconsin Medicaid issues billing performing, group, and nonbilling performing provider numbers to physician services providers.

Responsibilities section of the All-Provider Handbook for general information about provider numbers.

Billing Performing Provider Numbers (Issued to Physicians and Residents)

Physicians and residents are issued a billing performing provider number that allows them to identify themselves on claims (and other forms, when applicable) as either the biller of services performed or the performer of services when a clinic or group is submitting claims for the services.

Group Billing Numbers (Issued to Clinics)

Physician clinics and group practices are issued group billing numbers. Individual providers within a physician clinic or group practice are also required to be Medicaid certified because most groups are required to identify the performer of the service on claims (and other forms, when applicable). Typically, a claim submitted with only a group billing number is denied; except for claims submitted by physician pathology and radiology groups.

Nonbilling Performing Provider Numbers (Issued to Physician Assistants)

Physician assistants are issued a nonbilling performing provider number. A nonbilling performing provider number may *not* be used to independently submit claims to Wisconsin Medicaid.

For changes in physical address and all supervisor changes, physician assistants are required to complete the Declaration of Supervision for Nonbilling Providers form, HCF 1182. The completion instructions and Declaration of Supervision for Nonbilling Providers form are located in Appendices 30 and 31 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Covered Physician Services

A covered service is a service, item, or supply for which Medicaid reimbursement is available when *all* program requirements are met. For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified provider to an eligible recipient. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription, and documentation requirements. Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about covered services, medical necessity, services that are not separately reimbursable, and emergency services.

Physician services covered by Wisconsin Medicaid are:

- Diagnostic services.
- Palliative services.
- Preventive services.
- Rehabilitative services.
- Therapeutic services.

Procedure Codes and Modifiers

Covered E&M, medicine, and surgery services are identified by the CPT and Healthcare Common Procedure Coding System (HCPCS) procedure codes listed in Appendix 1 of this section. Appendix 2 of this section defines the allowable modifiers for these services. Refer to the physician maximum allowable fee schedule for the most current list of allowable procedure codes and modifiers.

Wisconsin Medicaid does not cover all services identified by CPT or HCPCS codes (e.g., fertility-related services are not covered). Other CPT and HCPCS codes have limitations (e.g., require PA). Providers are required to use the most current fee schedule in conjunction with the most current CPT and HCPCS references to determine coverage of services.

Providers are required to use the most current fee schedule in conjunction with the most current CPT and HCPCS references to determine coverage of services.

Category III Codes

Wisconsin Medicaid covers a limited number of services identified by Category III Emerging Technology CPT codes. Category III codes are temporary codes for emerging technology, services, and procedures. Category III codes consist of four numbers followed by the letter “T.” Refer to the physician fee schedule for allowable Category III codes.

Category II Codes

Wisconsin Medicaid does not cover services identified by Category II Performance Measurement CPT codes. Category II codes consist of four numbers followed by the letter “F.”

Place of Service Codes

Providers are required to indicate two-digit place of service (POS) codes on claims and other forms submitted to Wisconsin Medicaid. Refer to Appendix 3 of this section for a list of allowable POS codes for E&M, medicine, and surgery services.

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.

Physician services providers may not receive Medicaid reimbursement for services mentioned in HFS 107.06(5), Wis. Admin. Code.

Recipient Eligibility

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.

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

- The Automated Voice Response System.
- Commercial eligibility verification vendors (accessed through software, magnetic stripe card readers, and the Internet).
- 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions.
- Provider Services.

Refer to the Recipient Eligibility section of the All-Provider Handbook for more information.

Retroactive Eligibility

Physician services providers should do the following when a recipient is granted retroactive eligibility and the service performed:

- *Required PA.* If a provider performed a service that required PA before the recipient became eligible for Wisconsin Medicaid, the provider should request that the PA request be backdated to the date of service and write “RETROACTIVE ELIGIBILITY” on the Prior Authorization Request Form (PA/RF), HCF 11018. Refer to the Prior Authorization section of the All-Provider Handbook for more information on backdating PA requests.
- *Was a sterilization procedure.* If the provider performed a sterilization procedure before the recipient became

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.

Due to federal regulations, Wisconsin Medicaid does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state.

eligible and the provider has met all federal regulations regarding the Medicaid-required Sterilization Consent Form, then a claim may be submitted to Wisconsin Medicaid for the sterilization. If the recipient did not sign the consent form at least 30 days prior to the procedure, the provider will not receive reimbursement. Refer to the Surgery Services chapter of this section for more information about sterilizations.

- *Was a hysterectomy procedure.* If the recipient underwent a hysterectomy, the hysterectomy may be reimbursed if the provider attests in a signed, written statement attached to the CMS 1500 paper claim that the recipient was, at a minimum:
 - ✓ Informed that the surgery would make her permanently incapable of reproducing.
 - ✓ Already sterile.
 - ✓ In a life-threatening situation that required a hysterectomy.

Refer to the Surgery Services chapter of this section for more information about hysterectomies.

Non-U.S. Citizens — Emergency Services

Non-U.S. citizens who are not qualified aliens are eligible for Wisconsin Medicaid services only in cases of acute emergency medical conditions. Providers should use the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably

expect the absence of immediate medical attention to result in:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Due to federal regulations, Wisconsin Medicaid does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the county/tribal social or human services agency for a determination of Wisconsin Medicaid eligibility. Providers may complete the Certification of Emergency for Non-U.S. Citizens form, HCF 1162, for patients to take to the county/tribal social or human services agency in their county of residence where the decision of Medicaid eligibility is made. The completion instructions and Certification of Emergency for Non-U.S. Citizens form can be downloaded and printed from the Medicaid Web site or obtained from the Recipient Eligibility section of the All-Provider Handbook. Providers without Internet access may call Provider Services to request this form.

Recipient Copayment

Wisconsin Medicaid requires providers to collect copayment from recipients for certain services. Providers are required to make a reasonable attempt to collect the copayment unless the provider determines that the cost of

collecting the copayment exceeds the amount to be collected.

Certain groups of recipients and certain Medicaid-covered services are exempt from copayments. In addition, copayments are exempt for technical and professional components of diagnostic tests when the service is not billed as a global procedure. Refer to the Recipient Eligibility section of the All-Provider Handbook for more information about exemptions and other information about copayments.

Copayment for Physician Services

Copayment amounts for physician services are listed in the following table.

Copayment Amounts	
Evaluation and management services (each office visit, hospital admission, or consultation), based on the maximum allowable fee:	
• Up to \$10.00	\$0.50
• From \$10.01 to \$25.00	\$1.00
• From \$25.01 to \$50.00	\$2.00
• Over \$50.00	\$3.00
Surgery services (each)	\$3.00
Diagnostic services (each)	\$2.00
Allergy testing (per date of service)	\$2.00

Fee schedules list Medicaid's maximum allowable fee for each procedure code. The maximum allowable fee amount determines the copayment amount providers may request from a recipient for most physician services. The physician fee schedule may be obtained from the Provider section of the Medicaid Web site. Providers without Internet access may call Provider Services to order fee schedules.

A recipient's copayment for physician services is limited to \$30.00 cumulative, per physician *or* clinic (using a group billing number), per calendar year.

Documentation Requirements

As stated in HFS 106.02(9), Wis. Admin. Code, providers are required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records. A dated clinician's signature must be included in all medical notes.

Refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for more information about documentation requirements.

Prior Authorization

Prior authorization is required for certain services before they are provided. Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved PA/RF. If the provider delivers a service either before the grant date or after the expiration date of an approved PA request 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.

Prior authorization does not guarantee reimbursement. To receive Medicaid reimbursement, *all* Medicaid requirements must be met. For more information about general PA requirements, obtaining PA forms and attachments, and submitting PA requests, refer to the Prior Authorization section of the All-Provider Handbook.

Physician Services Requiring Prior Authorization

Appendix 15 of this section includes a list of physician services requiring PA.

Prior authorization is required for certain services before they are provided.

Prior Authorization Request Forms and Attachments

Physician services providers should use the following Wisconsin Medicaid forms for requesting PA:

- Prior Authorization Request Form.
- Prior Authorization/Physician Attachment (PA/PA), HCF 11016.
- Prior Authorization/"J" Code Attachment (PA/JCA), HCF 11034.
- Prior Authorization/Physician Otological Report (PA/POR), HCF 11019.
- Prescription drug PA forms.

Prior Authorization Request Form

The PA/RF functions as the cover page of the PA request. Providers are required to complete the basic provider, recipient, and service information on the PA/RF. The PA/RF completion instructions for physician services are located in Appendix 16 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site. Refer to Appendix 17 for a sample PA/RF.

Prior Authorization/Physician Attachment

The PA/PA allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service(s). Physician services providers should use the PA/PA for most services requiring PA. The completion instructions and a sample PA/PA are located in Appendices 18 and 19 of this section. The PA/PA can be downloaded and printed from the Medicaid Web site or photocopied from Appendix 20 of this section.

Prior Authorization/"J" Code Attachment

The purpose of the PA/JCA is to document the medical necessity of physician-administered drugs requiring PA. The completion instructions and PA/JCA are located in Appendices 21 and 22 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Prior Authorization/Physician Otological Report

Completion of the PA/POR begins the process by which PA is obtained for a hearing aid by a hearing instrument specialist. The physician gives page one (or a copy) of the completed PA/POR to the recipient and keeps page two (or a copy of it) in the recipient's medical records. The recipient then takes the PA/POR to any Medicaid-certified hearing instrument specialist to receive a hearing aid. The completion instructions and PA/POR are located in Appendices 23 and 24 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Prescription Drug Prior Authorization Forms

Prescribers are required to complete prescription drug PA forms for selected drugs and submit them to the pharmacy where the prescription will be filled. Providers may fax or mail the completed drug PA form to the pharmacy or send the completed drug PA form with the recipient. Prescribers should *not* send prescription drug PA forms directly to Wisconsin Medicaid. Refer to the Prescription Requirements chapter of this section for more information.

Experimental Services

Wisconsin Medicaid does not cover services that are considered to be experimental in nature. A service is considered experimental when Wisconsin Medicaid determines that the procedure or service is not an effective or proven treatment for the condition for which it is intended.

Wisconsin Medicaid resolves questions relative to the experimental or nonexperimental nature of a procedure based on the following, as appropriate:

- The judgment of the medical community.
- The extent to which other health insurance sources cover a service.

Wisconsin Medicaid does not cover services that are considered to be experimental in nature.

- The current judgment of experts in the applicable medical specialty area.
- The judgment of a committee formed by the External Review Organization at the request of Wisconsin Medicaid.

Specialized Medical Vehicle Services

Wisconsin Medicaid covers specialized medical vehicle (SMV) services if the transportation is to and from a facility where the recipient receives Medicaid-covered services and the recipient meets the eligibility requirements. To be eligible for SMV services, a recipient must be indefinitely disabled, legally blind, or temporarily disabled *and* must have a medical condition that contraindicates safe travel by common carrier such as bus, taxi, or private vehicle.

If a recipient meets the eligibility requirements, a physician, physician assistant, nurse practitioner, or nurse midwife should complete a Certification of Need for Specialized Medical Vehicle Transportation form, HCF 1197. The completion instructions and Certification of Need for Specialized Medical Vehicle Transportation form are located in Appendix 28 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

If the recipient does not meet the criteria for SMV services, the medical provider should not complete the form. Instead, the provider should refer the recipient to the Medicaid transportation coordinator in his or her county/tribal social or human services agency.

Inconvenience or lack of timely transportation are not valid justifications for the use of SMV transportation. The presence of a disability does not by itself justify SMV transportation.

The medical provider gives a copy of the completed form to the recipient who then gives the form to the SMV provider. The medical provider does not need to keep a copy of the completed form on file, but he or she is required to document the medical condition necessitating SMV transportation in the recipient's medical record.

Physicians are required to complete a new Certification of Need (CON) form upon expiration. For recipients who are indefinitely disabled, the CON is valid for 365 days from the date the medical provider signed the form. For recipients who are temporarily disabled, the CON is valid for the period indicated on the form, which must not exceed 90 days from the date the medical provider signed the form.

Medical providers must not complete the forms retroactively for SMV providers or recipients.

Providers may not charge recipients for completing the Certification of Need for Specialized Medical Vehicle Transportation form. Wisconsin Medicaid will reimburse providers at the lowest level E&M CPT procedure code if the recipient is in the office when the form is completed and no other medical service is provided.

Refer to the Prescription Requirements chapter of this section for information about prescriptions for SMV trips exceeding one-way upper mileage limits.

Providers may not charge recipients for completing the Certification of Need for Specialized Medical Vehicle Transportation form.

Evaluation and Management Services

Wisconsin Medicaid covers most of the categories of E&M services described in *Current Procedural Terminology* (CPT).

Evaluation and management (E&M) services include office visits, hospital visits, and consultations. Specific services include examinations, evaluations, treatments, preventive pediatric and adult health supervision, and similar medical services.

Wisconsin Medicaid covers most of the categories of E&M services described in *Current Procedural Terminology* (CPT). Refer to Appendix 1 of this section for Medicaid-covered E&M services. Wisconsin Medicaid does *not* cover services in the following CPT categories:

- Prolonged Physician Services Without Direct Patient Contact.
- Case Management Services.
- Care Plan Oversight Services.
- Counseling and/or Risk Factor Reduction Intervention.
- Special E&M Services.

Wisconsin Medicaid does not cover services provided in group settings or telephone conversations between the provider and the recipient, except for outpatient mental health and substance abuse services. (Refer to mental health/substance abuse service-specific publications for more information.) Evaluation and management services must be provided to recipients on a one-on-one basis.

Concurrent Care

Wisconsin Medicaid covers E&M services provided on the same date of service (DOS) by two or more physicians to a recipient during an inpatient hospital or nursing home stay only when medical necessity is documented in the recipient's medical record.

Consultations

Evaluation and management consultations (CPT procedure codes 99241-99275) are covered by Wisconsin Medicaid when provided to a recipient at the request of another provider or when medically necessary and appropriate. Consultation procedure codes are not reimbursed when the recipient is an established patient of the provider billing the consultation. If a provider assumes responsibility for management of the recipient, the use of consultation procedure codes is no longer appropriate.

Covered Consultations

An E&M consultation requires face-to-face contact between the consultant and the recipient. A consultation must always include a written report that becomes a part of the recipient's permanent medical record.

Claims for consultations should include the referring provider's name and Medicaid provider number.

Critical Care and Prolonged Services

Wisconsin Medicaid reimburses up to four hours per DOS for critical care (CPT procedure codes 99291-99292) and prolonged services (CPT procedure codes 99354-99357 and 99360).

To request reimbursement for time in excess of four hours per DOS, providers should submit an Adjustment/Reconsideration Request, HCF 13046, for an allowed claim. Supporting clinical documentation (e.g., a history and physical exam report or a medical progress note) that identifies why

reimbursement for services in excess of four hours is requested must be included. Refer to the Medicaid Web site for a copy of the Adjustment/Reconsideration Request.

Wisconsin Medicaid only reimburses prolonged care services (CPT procedure codes 99354-99357 and 99360) if there is face-to-face contact between the provider and the recipient. Prolonged care services without face-to-face contact (CPT codes 99358 and 99359) are not covered by Wisconsin Medicaid.

Ambulance Services

Critical care services provided by physicians in an air or ground ambulance are reimbursed under either critical care or prolonged care procedure codes. Claims for services provided in an ambulance must be submitted on a paper claim with a copy of the physician’s clinical record attached.

Wisconsin Medicaid does not reimburse physicians for supervising from the home base of a hospital’s emergency transportation unit or for supervising in the ambulance.

Emergency Department Services

When a specific surgical procedure (e.g., fracture care) is provided as an emergency service, an E&M procedure code is ordinarily not reimbursed for the same recipient on the same DOS. The reimbursement for the surgical procedure includes payment for E&M services as well.

Separate reimbursement may be available for emergency E&M services and emergency services that are of unusually high complexity. Providers in these situations may submit an Adjustment/Reconsideration Request for the allowed surgical claim. Attach a copy of the emergency department visit report to the completed Adjustment/Reconsideration Request. The situations and reason for requesting additional/separate reimbursement should be explained in the “Other/comments”

portion of the Adjustment Information section of the form.

Evaluation and Management Services Provided with Surgical Procedures

If a provider performs an office or a hospital visit and a surgical procedure on the same DOS for the same recipient, the provider will receive reimbursement for the surgical procedure only. However, if the surgery is a minor surgery (as determined by Wisconsin Medicaid), the provider may submit an adjustment request for the allowed surgery claim to request additional reimbursement for the E&M service. Refer to the Claims Information section of the All-Provider Handbook for more information.

If the E&M service was unrelated to the surgery, the E&M service may be reimbursed if it is billed under a different diagnosis code than the diagnosis code for the surgery.

Family Planning Services

Family planning services are defined as services performed to enable individuals of childbearing age to determine the number and spacing of their children. This includes minors who are sexually active. To enable the state to obtain Federal Financial Participation funding for family planning services, the accurate completion of the following elements on the claim is essential:

- Diagnosis code from V25 series.
- Appropriate diagnosis code reference to procedure code.
- Family Planning Indicator “F.”

Hospital Services

Wisconsin Medicaid ordinarily reimburses physicians for a moderate-level hospital admission procedure code if the physician has provided an E&M service or consultation at

Wisconsin Medicaid only reimburses prolonged care services (CPT procedure codes 99354-99357 and 99360) if there is face-to-face contact between the provider and the recipient.

the highest level of service in the seven days prior to the hospital admission date.

Nursing Home Visits

Wisconsin Medicaid reimburses one routine nursing home visit per calendar month per recipient. If a physician visits a nursing home recipient more frequently, medical records must document the medical necessity of the additional visits.

When submitting a claim for a nursing home visit, use the most appropriate CPT procedure code based on the level of service provided.

Observation Care

Observation care procedure codes 99217-99220 or 99234-99236 are covered by Wisconsin Medicaid. Observation care includes all E&M services performed by the admitting physician on the date a recipient is admitted into observation care. This includes related services provided at other sites and all E&M services provided in conjunction with the admission into observation status.

Only the admitting physician may submit a claim for observation care. Other physicians are required to use another appropriate E&M outpatient or consultation procedure code.

When submitting claims for observation care, use the appropriate CPT procedure code. Only one observation care procedure code may be reimbursed per recipient, per DOS, per provider. Observation care codes are not reimbursed for recipients admitted into hospital inpatient care on the same DOS. Only place of service (POS) codes “22” (outpatient hospital) and “23” (emergency room — hospital) may be indicated on claims for observation care.

Office and Other Outpatient Visits

Established Patient

An established patient is one who has, within the past three years, received professional services from the same physician or another physician of the same specialty who belongs to the same group practice.

New Patient

A new patient is defined as a patient who is new to the provider and whose medical and administrative records need to be established. A new patient has not received professional services from either the physician or group practice within the past three years.

Office Visit Daily Limit

Wisconsin Medicaid reimburses only one office visit per recipient, per provider, per DOS. However, an established patient office visit may be reimbursed in addition to a preventive medicine office visit by the same provider on the same DOS if an abnormality is encountered or a pre-existing problem is addressed in the process of performing the preventive medicine visit. The abnormality/problem must be a significant, medically necessary, separately identifiable E&M service that is documented in the recipient's medical record. In addition, the abnormality/problem must be significant enough to require additional work to perform the key component of a problem-oriented E&M service.

Separate reimbursement for more than one E&M visit on the same DOS as a preventive visit are subject to post-pay review and may be recouped if documentation is inadequate to justify separate payment.

Office Located in Hospital

Physicians may submit claims for services performed in a physician's office that is located

Wisconsin Medicaid reimburses one routine nursing home visit per calendar month per recipient.

in an outpatient hospital facility with POS code “11” (office).

Office Visits and Counseling

A physician or a physician’s designee may be reimbursed for counseling (including counseling a recipient for available courses of treatment) using E&M office visit procedure codes 99201-99215, even if counseling was the only service provided during the visit. Counseling may include the discussion of treatment options that are not covered by Wisconsin Medicaid (e.g., experimental services). Counseling procedure codes 99401-99404 are non-reimbursable as physician services.

Physician Counseling Visits Under s. 253.10, Wis. Stats.

Refer to the Surgery Services chapter of this section for more information about physician counseling visits related to abortions.

Preventive Medicine Services

Preventive medicine services are those office visits that relate to preventive medicine E&M of infants, children, adolescents, and adults. Preventive medicine services include the following:

- Counseling.
- Anticipatory guidance.
- Risk factor reduction interventions.

Annual Physicals

Wisconsin Medicaid reimburses a maximum of one comprehensive, routine physical examination per calendar year per recipient. Recipients may use this examination to fulfill employment, school entrance, or sports participation requirements.

Note: Wisconsin Medicaid considers preventive medicine visits for recipients under age 21 as HealthCheck visits.

HealthCheck Screenings

HealthCheck is Wisconsin Medicaid’s federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck services consist of a comprehensive health screening of Medicaid recipients under 21 years of age that includes *all* the following:

- A comprehensive health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical exam.
- An age-appropriate vision screen.
- An age-appropriate hearing screen.
- An oral assessment plus referral to a dentist beginning at age 3.
- Appropriate immunizations.
- Appropriate laboratory tests.

Preventive medicine procedure codes 99381-99385 or 99391-99395 should only be used by providers when submitting claims for comprehensive HealthCheck screens. Other preventive visits should be billed using the appropriate office visit code. Providers should also indicate modifier “UA” with the appropriate procedure code if a comprehensive screen results in a referral for further evaluation and treatment. If a comprehensive HealthCheck screen does *not* result in a referral for further evaluation or treatment, providers should *only* indicate the appropriate procedure code, not the modifier.

Interperiodic Visits

Wisconsin Medicaid covers medically necessary interperiodic screening exams to follow up on detected problems or conditions. Examples of interperiodic screenings include:

- Immunizations.
- Retesting for an elevated blood lead level.
- Retesting for a low hematocrit.

Providers should submit claims for interperiodic visits using the appropriate office visit procedure code (99201-99205, 99211-99215)

Wisconsin Medicaid reimburses a maximum of one comprehensive, routine physical examination per calendar year per recipient.

along with a preventive medicine diagnosis code.

For more information about HealthCheck, refer to the HealthCheck provider page of the Medicaid Web site. Providers without Internet access may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

HealthCheck "Other Services"

HealthCheck services consist of a comprehensive health screening of Medicaid recipients under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by Wisconsin Medicaid or that exceed Medicaid limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed by Wisconsin Medicaid through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary services are available to recipients under 21 years of age.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about HealthCheck "Other Services" including, but not limited to, requirements that must be met for a service to be reimbursed through HealthCheck "Other Services."

Tobacco Cessation Services

Tobacco cessation services are reimbursed as part of an E&M office visit provided by a physician, physician assistant, nurse practitioner, and ancillary staff. Services must be one-on-one, face-to-face between the provider and the recipient. Wisconsin Medicaid does not cover group sessions or telephone conversations between the provider and recipient under the E&M procedure codes.

Ancillary staff can provide tobacco cessation services only when under the direct, on-site supervision of a Medicaid-certified physician. When ancillary staff provide tobacco cessation services, Wisconsin Medicaid reimburses up to a level-two office visit (CPT code 99212). The supervising provider is required to be listed as the performing provider on the claim.

Drugs for Tobacco Cessation

Wisconsin Medicaid covers legend drugs for tobacco cessation. Prescribers are required to indicate the appropriate diagnosis on the prescription.

Nicotine gum or patches available over the counter are not covered by Wisconsin Medicaid.

Tobacco cessation services are reimbursed as part of an E&M office visit provided by a physician, physician assistant, nurse practitioner, and ancillary staff.

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Refer to the Online Handbook
for current policy

M Medicine Services

A physician referring a recipient to a hearing instrument specialist for a hearing aid must complete a Prior Authorization/Physician Otological Report (PA/POR), HCF 11019.

Wisconsin Medicaid covers most of the categories of medicine services described in *Current Procedural Terminology* (CPT). Refer to Appendix 1 of this section for Medicaid-covered medicine services. Providers should refer to other sources for the following services:

- Psychiatric services — Mental Health and Other Drug Abuse Services Handbook, and related *Wisconsin Medicaid and BadgerCare Updates*.
- Ophthalmology services — Vision Care Services Handbook and related *Updates*.

Allergy Tests

Claims for allergy tests must include the appropriate CPT procedure code(s) and the quantities of items provided or tests performed.

Audiometry

Basic comprehensive audiometry includes all of the following:

- Pure tone air audiometry.
- Pure tone bone audiometry.
- Speech audiometry, threshold.
- Speech audiometry, discrimination.

If a claim is submitted for basic comprehensive audiometry testing in combination with any of the individual components of the comprehensive test for the same recipient on the same date of service (DOS), only the comprehensive audiometry testing is reimbursed.

A physician referring a recipient to a hearing instrument specialist for a hearing aid must complete a Prior Authorization/Physician Otological Report (PA/POR), HCF 11019. The physician should give page one (or a copy) of the PA/POR to the recipient and keep page

two (or a copy of it) in the recipient's medical records.

The completion instructions and PA/POR are located in Appendices 23 and 24 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Biofeedback

Wisconsin Medicaid reimburses physicians and physician assistants for biofeedback training, procedure codes 90901 and 90911. Only psychiatrists may be reimbursed for individual psychophysiological therapy incorporating biofeedback, procedure codes 90875 and 90876. For service-specific information about mental health and substance abuse services, refer to the Medicaid Web site. Providers without Internet access may call Provider Services at (800) 947-9627 or (608) 221-9883.

Chemotherapy

When chemotherapy for a malignant disease is provided in a physician's office, reimbursement is allowed for the following:

- Evaluation and management (E&M) visits.
- The drug, including injection of the drug.
- Therapeutic infusions.
- Supplies.
- Physician-administered oral anti-emetic drugs.

Each of these services may be reimbursed separately.

Refer to Appendix 1 of this section for allowable E&M services procedure codes. Use procedure code 99070 for supplies and materials provided by the physician.

Wisconsin Medicaid covers chemotherapy drugs (Healthcare Common Procedure Coding

System [HCPCS] codes J9000-J9999). Reimbursement for these procedure codes includes the cost of the drug and the charge for administering the drug. (If the physician's office does not supply the drug, use procedure code 90782 or 90784 on claims for the injection. Use the appropriate procedure code for the infusion when performed by the physician.)

When chemotherapy for a malignancy is provided in an inpatient hospital, outpatient hospital, or nursing home setting, physician services providers may receive reimbursement for the E&M visit only.

Anti-Emetic Drugs

Wisconsin Medicaid covers physician-administered anti-emetic drugs for recipients receiving chemotherapy. The appropriate HCPCS "Q" code should be indicated when submitting a claim for a physician-administered oral anti-emetic drug for a Medicaid recipient receiving chemotherapy. Before submitting a claim, providers are responsible for verifying that a pharmacy is not already billing for an anti-emetic drug given to a recipient for the same DOS.

Clozapine Management

Clozapine management is a specialized care management service that may be required to ensure the safety of recipients who are receiving this psychoactive medication.

Wisconsin Medicaid reimburses clozapine separately for outpatient and nursing home residents. Clozapine management is reimbursable only for outpatient services. Refer to Appendix 26 of this section for more information about Medicaid coverage of clozapine management.

Evoked Potentials

Only audiologists and physicians with specialties of neurology, otolaryngology, ophthalmology, physical medicine and

rehabilitation, anesthesiology, and psychiatry can be reimbursed for evoked potential testing.

Wisconsin Medicaid covers the following evoked potential tests:

- Brain stem evoked response recording.
- Visual evoked potential study.
- Somatosensory testing.
- Intraoperative neurophysiological testing reimbursed by the hour.

These evoked potential tests are allowed once per day per recipient. When two or more types of evoked potential tests are performed on the same DOS (e.g., brain stem and visual), reimbursement is 100 percent of the Medicaid maximum allowable fee for the first test, with a lesser amount for the second and subsequent tests.

End-Stage Renal Disease Services

Physician services providers should submit claims with HCPCS procedure codes G0308-G0327 for professional end-stage renal disease (ESRD)-related services. These services may be reimbursed once per calendar month per recipient. Recipient copayments are deducted for these services as appropriate.

Dialysis Treatment Provided Outside the Recipient's Home

Providers should submit claims with procedure codes G0308-G0319 for ESRD recipients who are receiving dialysis treatment somewhere other than in their home. Providers should indicate the appropriate procedure code based on the age of the recipient and the number of face-to-face visits per month. The visits may occur in the physician's office, an outpatient hospital or other outpatient setting, or the recipient's home, as well as the dialysis facility. If the visits occur in multiple locations, providers should indicate on claims the place of service code where most of the visits occurred.

When two or more types of evoked potential tests are performed on the same DOS (e.g., brain stem and visual), reimbursement is 100 percent of the Medicaid maximum allowable fee for the first test, with a lesser amount for the second and subsequent tests.

Topical application of fluoride to a child's teeth is a safe and effective way to prevent tooth decay as part of a comprehensive oral health program.

If an ESRD recipient is hospitalized during the month, the physician may submit a claim with the code that reflects the appropriate number of face-to-face visits that occurred during the month on days when the recipient was not in the hospital.

Indicate the first DOS of the month and always indicate a quantity of "1.0" to represent a month of care. Do not report the specific dates of each dialysis session on the claim.

Home Dialysis Recipients

Providers should submit claims with procedure codes G0320-G0323 for home dialysis ESRD recipients. The procedure codes differ according to age, but do not specify the frequency of required visits per month.

When submitting claims for these procedure codes, report the first DOS of the month and always indicate a quantity of "1.0" to represent a month of care. Do not report the specific dates of each dialysis session.

Home Dialysis Recipients Who are Hospitalized

Procedure codes G0324-G0327 are for home dialysis ESRD recipients who are hospitalized during the month.

These procedure codes can be used to report daily management for the days the recipient is not in the hospital. For example, if a home dialysis recipient is in the hospital for 10 days and is cared for at home the other 20 days during the month, then 20 units of one of the codes would be used. If a home dialysis recipient receives dialysis in a dialysis center or other facility during the month, the physician is still reimbursed for the management fee and may not be reimbursed for procedure codes G0308-G0319.

Paper Claims

When submitting claims for procedure codes G0324-G0327, report the DOS for ESRD-related care within a calendar month, with the first DOS as the "From DOS" and the last

DOS as the "To DOS." Providers submitting paper claims may indicate up to four DOS per detail line. Indicate the actual number of days under the physician's care within the calendar month as the quantity. The quantity must match the number of DOS. Refer to Appendix 8 for a sample CMS 1500 claim form for ESRD services.

Electronic Billing

Providers submitting 837 Health Care Claim: Professional (837P) transactions should indicate individual DOS per detail line. Providers may indicate a range of dates per detail line using the 837P transaction only when the service is performed on consecutive days.

Fluoride — Topical Applications

Topical application of fluoride to a child's teeth is a safe and effective way to prevent tooth decay as part of a comprehensive oral health program.

Coverage

Wisconsin Medicaid recommends that children under age 5 who have erupted teeth receive topical fluoride treatment. Children at low or moderate risk of early childhood caries should receive one or two applications per year; children at higher risk should receive three or four applications per year.

The most accepted mode of fluoride delivery in children under age 5 is a fluoride varnish. Over-the-counter (OTC) mouth rinses are not covered by Wisconsin Medicaid.

Submitting Claims

When submitting claims for topical fluoride treatment, indicate HCPCS procedure code D1203 (Topical application of fluoride [prophylaxis not included]; child). Providers may also submit claims with HealthCheck and office visit HCPCS procedure codes for these services.

In cases where more than two fluoride treatments per year are medically necessary, providers are required to retain supporting clinical documentation in the recipient's file indicating the need for additional treatments.

Ancillary staff (e.g., physician assistants, nurse practitioners) are required to follow billing procedures as listed in the Reimbursement chapter of this section.

Wisconsin Medicaid will separately reimburse providers for the appropriate level office visit or preventive visit at which the fluoride application was performed.

Training Materials

Training materials describing how providers may perform lift-the-lip oral screenings, apply fluoride varnish to a small child's teeth, and provide basic oral health guidance to parents is available on the Medicaid Web site.

Hospital Admissions

An external review organization (ERO), under contract with the Department of Health and Family Services (DHFS), reviews the medical necessity of certain inpatient hospital admissions.

Complete medical record documentation is essential for the ERO at the time that the ERO requests the recipient's medical record from the hospital. Physicians must be certain that the recipient's record adequately documents the recipient's condition and continued need for inpatient care.

Hospitals are responsible for notifying the ERO relative to the following admissions:

- All elective medical admissions (excluding maintenance chemotherapy). Wisconsin Medicaid defines an elective hospitalization as an admission that may be delayed without substantial risk to the patient.
- All elective admissions for surgical procedures identified on the ERO's outpatient procedure list.

- All substance abuse admissions to general hospitals (all ages).
- All elective psychiatric admissions to general hospitals (all ages).
- All substance abuse admissions of individuals under age 21 to a specialty hospital (Institution for Mental Disease [IMD]).
- All psychiatric admissions of individuals under age 21 to specialty hospitals (IMD).
- All elective admissions to IMD for recipients age 65 or over.

Certificate of Need Requirements for Recipients Admitted to an Institution for Mental Disease

Federal and state regulations require IMDs to conduct and document a certification of need (CON) assessment for all recipients under the age of 21 who are admitted for elective/urgent or emergency psychiatric or substance abuse treatment services.

The CON assessments must be completed by a team of professionals, including at least one physician, working in cooperation with the hospital. The completed CON form must be readily available for ERO or DHFS review. For more information about CON requirements, refer to the Hospital Services Handbook, which is available on the Medicaid Web site. Providers without Internet access may call Provider Services.

Immunizations

Wisconsin Medicaid covers the immunizations identified by CPT subsections "Immune Globulins" (procedure codes 90281-90399) and "Vaccines, Toxoids" (procedure codes 90476-90749).

Immune globulin procedure codes and the unlisted vaccine/toxoid procedure code are manually priced by Wisconsin Medicaid's pharmacy consultant. To be reimbursed for

Federal and state regulations require IMDs to conduct and document a certification of need (CON) assessment for all recipients under the age of 21 who are admitted for elective/urgent or emergency psychiatric or substance abuse treatment services.

these codes, physicians are required to attach the following information to a paper claim:

- Name of drug.
- National Drug Code (NDC).
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Medicaid reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes *includes* reimbursement for the administration component of the immunization, contrary to CPT's description of the procedure codes. Procedure codes for administration are *not* separately reimbursable.

Vaccines for Children Program

The Vaccines for Children (VFC) program provides certain vaccines to physicians for children ages 19 and under. Refer to the Wisconsin Immunization Program Web site at dhfs.wisconsin.gov/immunization/vfc.htm to obtain more information about the VFC program. Providers may also call the VFC program at (608) 267-5148 if Internet access is not available.

Providers are required to submit claims with the appropriate vaccine procedure code for all vaccines, including those provided through the VFC program. Providers are not reimbursed for the vaccine component, only the administration component, for vaccines provided through the VFC. The Immunization Program sends the vaccines at no cost to providers who give immunizations to Medicaid recipients.

Vaccines that are commonly combined, such as MMR or DTaP, are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the recipient's medical record.

If a patient encounter occurs in addition to the administration of the injection, physicians may

receive reimbursement for the appropriate E&M procedure code that reflects the level of service provided at the time of the vaccination. If an immunization is the only service provided, the lowest level E&M office or other outpatient service procedure code may be reimbursed, in addition to the appropriate vaccine procedure code(s).

Vaccines for Recipients Older than Age 19

For recipients older than age 19, Medicaid reimbursement for the immunization procedure code includes both reimbursement for the vaccine component as well as the administration component.

Synagis® Coverage

Synagis® (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by respiratory syncytial virus in premature, high-risk infants. The treatment season for Synagis® is from October through April.

Providers are required to indicate CPT code 90378 (Respiratory syncytial virus immune globulin [RSV-IgIM], for intramuscular use, 50 mg, each) with the appropriate unit that indicates administered dosage (e.g., 1 unit equals 50 mg) on each claim submission. Providers may submit claims with partial quantities of Synagis®.

Providers should *not* indicate HCPCS procedure code J3490 (Unclassified drugs) when submitting claims to Wisconsin Medicaid for Synagis®. Claims submitted for Synagis® with HCPCS procedure code J3490 will be denied.

Age Restrictions

Children must be under age 24 months to begin receiving Synagis®. If the child turns 2 years old during the treatment season, the treatment may continue if the provider submits a completed CMS 1500 paper claim form, a request for an age restriction override, and

Medicaid reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes *includes* reimbursement for the administration of the immunization, contrary to CPT's description of the procedure codes.

documentation in support of the clinical need for a medical consultant review to:

Wisconsin Medicaid
Written Correspondence
6406 Bridge Rd
Madison WI 53784-0005

Provider-Administered Drugs

Procedure codes for Medicaid-covered provider-administered drugs are listed in the physician services maximum allowable fee schedules. Providers should use the appropriate fee schedule in conjunction with the most recent HCPCS coding book for descriptions.

Diagnosis Restrictions

Diagnosis restrictions that apply to NDCs also apply to corresponding HCPCS codes when billed as provider-administered drugs. Wisconsin Medicaid requires a valid and acceptable *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code on claims for selected provider-administered drugs. Diagnosis code restrictions are based on Food and Drug Administration-approved indications and compendium standards.

Refer to Appendix 32 of this section for a list of drugs that are diagnosis restricted and the respective HCPCS codes, allowable diagnosis codes, and disease descriptions. This list may be updated periodically. Refer to the Physician page of the Medicaid Web site for an updated list.

If the recipient's diagnosis is not one of the allowable diagnoses for the code, providers are required to obtain PA.

Prior Authorization Requirements

Physician services providers are required to obtain PA for provider-administered drugs in Appendix 15 of this section and for provider-administered drugs that are not provided with

one of the allowable diagnosis codes listed in Appendix 32. Providers are required to use the Prior Authorization/"J" Code Attachment (PA/JCA), HCF 11034, along with the Prior Authorization Request Form (PA/RF), HCF 11018, to request PA.

Providers are required to include with the PA request peer-reviewed medical literature from scientific medical or pharmaceutical publications in which original manuscripts are rejected or published only after having been reviewed by unbiased independent experts. Only the diagnosis codes listed in Appendix 32 of this section are reimbursable without PA.

Unclassified Drugs

Providers should *not* submit claims with HCPCS procedure code J3490 when there is another procedure code that better describes the drug. Claims with J3490 will be denied if there is a more specific code that may be used.

Procedure code J3490 requires PA *only* when the drug may also be used as a fertility drug.

To be reimbursed for an unclassified drug that does not require PA or a HCPCS code that does not have a maximum allowable fee listed in the fee schedule for physicians, providers are required to submit a paper CMS 1500 claim form and attach the following information:

- Name of drug.
- National Drug Code.
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Reimbursement

Reimbursement for provider-administered drugs *includes* reimbursement for the administration of the drug. Therefore, providers should not submit claims for an administration code (i.e., CPT procedure codes 90782-90788 or HCPCS codes G0351-G0358) concurrently with a drug code or concurrently with any

Reimbursement for provider-administered drugs *includes* reimbursement for the administration of the drug.

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure.

other administration code except in the following instances:

- When the medication is supplied and independently billed by a pharmacy using an applicable NDC.
- When the recipient possesses and provides the medication for injection by a provider.

In these situations, only one administration procedure code may be reimbursed for the same provider for the same recipient on the same DOS for the same provider-administered drug.

Laboratory Test Preparation and Handling Fees

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure. The physician who forwards the specimen is only reimbursed a handling fee.

When forwarding a specimen from a physician's office to an outside laboratory, submit claims for preparation and handling fees using procedure code 99000. When forwarding a specimen from someplace other than a physician's office to a laboratory, submit claims using procedure code 99001. It is not necessary to indicate the specific laboratory test performed on the claim.

A handling fee is not separately reimbursable if the physician is reimbursed for the professional and/or technical component of the laboratory test.

Additional Limitations

The following are additional limitations on reimbursement for lab handling fees:

1. One lab handling fee is reimbursed per provider, per recipient, per outside laboratory, per DOS, regardless of the number of specimens sent to the laboratory.
2. More than one handling fee is reimbursed when specimens are sent to two or more laboratories for one recipient on the same DOS. Indicate the number of laboratories and the total charges on the claim. The name of the laboratory does not need to be indicated on the claim; however, this information must be documented in the provider's records.
3. The DOS must be the date the specimen is obtained from the recipient.

Mental Health Services

Mental health services (except for biofeedback and pharmacological management) are reimbursable only for Medicaid-certified physicians with a psychiatric specialty.

Physicians interested in providing mental health services should refer to service-specific Medicaid publications, which may be downloaded from the Medicaid Web site, or may be obtained by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Psychiatric Medication Checks

Providers who are not certified as mental health providers and who perform medication checks for psychiatric patients are required to use HCPCS procedure code M0064 (Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders).

Providers of mental health services (e.g., psychiatrists, psychotherapists, or social workers) are required to use CPT code 90862 (Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy) for medication checks on psychiatric patients.

Claims submitted with the incorrect procedure code and provider type combination will be denied.

Screenings

The following are general principles for Medicaid coverage of screening and diagnostic procedures:

- Wisconsin Medicaid reimburses both screening and diagnostic tests and procedures under the appropriate procedure codes.
- Reimbursement for office visits is included with the reimbursement for surgical procedures, whether diagnostic or screening (e.g., colonoscopy, flexible sigmoidoscopy). Providers should not submit claims for office visits when performing surgical procedures on the same DOS.
- Laboratory and radiology screening and diagnostic procedures are separately reimbursable when submitted with an office visit procedure code on the same DOS.

Refer to Appendix 1 of this section for a list of covered screening procedure codes.

Screening Procedures Coverage

Providers should indicate screening procedure codes when submitting claims in the following instances:

- For routine tests or procedures performed to identify recipients at increased risk for diseases.
- When a recipient is asymptomatic or does not have a personal history of the disease

(or related conditions) for which the screening test is being performed.

Wisconsin Medicaid does not limit the frequency, age criteria, or reasons for screening; rather, this is left to best medical judgment based on standard medical practice and the patient's individual circumstances.

Claims for screenings must have the diagnosis code field completed (e.g., a preventive code). For example, a claim for a glaucoma screening could indicate ICD-9-CM diagnosis code V80.1 (Special screening for neurological, eye, and ear diseases; Glaucoma).

Diagnostic Procedures

Providers should indicate diagnostic procedure codes when submitting claims in the following instances:

- There are symptoms or other indications of a medical problem.
- To confirm a previous diagnosis.
- There is a personal history of a medical problem or related condition.
- During a screening, a problem or medical condition is found and a biopsy or other sample is taken for further study and analysis.

Service-Specific Information

The following information gives details about each kind of screening and/or when to request reimbursement for diagnostic services. Refer to Appendix 1 of this section for allowable screening procedure codes. Refer to CPT for diagnostic procedure codes.

Breast Cancer — Mammography

Wisconsin Medicaid does not have limitations on the frequency of mammography. Providers may be reimbursed for both a screening mammography and a diagnostic mammography for the same patient on the same DOS if they are performed as separate films. Reasons for the separate procedures

Claims for screenings must have the diagnosis code field completed (e.g., a preventive code).

must be documented in the recipient's medical record.

Colorectal Cancer

Providers may submit claims for a variety of colorectal cancer screening or diagnostic tests, including laboratory tests, flexible sigmoidoscopy, proctosigmoidoscopy, barium enema, and colonoscopy. Providers should indicate the HCPCS or CPT procedure code that best reflects the nature of the procedure. If abnormalities (e.g., polyps) are found during a screening colonoscopy or sigmoidoscopy and biopsies taken or other coverage criteria are met (e.g., personal history of colon cancer), then the CPT diagnostic procedure code should be indicated.

Glaucoma

Wisconsin Medicaid reimburses for glaucoma screening examinations when they are performed by or under the direct supervision of an ophthalmologist or optometrist. If a recipient has a previous history of glaucoma, indicate the CPT diagnostic procedure code when submitting a claim for services. In either case, Wisconsin Medicaid will not separately reimburse a provider for a glaucoma screening if an ophthalmological exam is provided to a recipient on the same DOS. Glaucoma screening and diagnostic examinations are included in the reimbursement for the ophthalmological exam.

Pap Smears

Wisconsin Medicaid covers both screening and diagnostic Pap smears. Providers may receive reimbursement for both a screening and diagnostic Pap smear for the same DOS if abnormalities are found during a screening procedure and a subsequent diagnostic procedure is done as a follow-up. Providers are required to document this in the recipient's medical record.

Pelvic and Breast Exams

Wisconsin Medicaid reimburses for a screening pelvic and breast exam if it is the only procedure performed on that DOS. A pelvic and breast exam (HCPCS procedure code G0101) performed during a routine physical examination or a problem-oriented office visit is not separately reimbursable but is included in the reimbursement for the physical examination or office visit. When using an E&M office visit procedure code, the time and resources for the pelvic and breast exam should be factored into the determination of the appropriate level for the office visit.

Prostate Cancer

Wisconsin Medicaid covers the following tests and procedures provided to an individual for the early detection and monitoring of prostate cancer and related conditions:

- **Screening Digital Rectal Examination (DRE)** — This test is a routine clinical examination of an asymptomatic individual's prostate for nodules or other abnormalities of the prostate.
- **Screening Prostate Specific Antigen (PSA) Blood Test** — This test detects the marker for adenocarcinoma of the prostate.
- **Diagnostic PSA Blood Test** — This test is used when there is a diagnosis or history of prostate cancer or other prostate conditions for which the test is a reliable indicator.

Reimbursement for a DRE is included in the reimbursement for a covered E&M or preventive medical examination when the services are furnished to a recipient on the same day. If the DRE is the only service provided, the applicable procedure code may be reimbursed. The screening and diagnostic PSA tests are separately reimbursable when performed on the same DOS as an E&M or preventive medical exam.

Providers may receive reimbursement for both a screening and diagnostic Pap smear for the same DOS if abnormalities are found during a screening procedure and a subsequent diagnostic procedure is done as follow-up.

Substance Abuse Services

Wisconsin Medicaid covers the following substance abuse services:

- Individual substance abuse therapy.
- Family substance abuse therapy.
- Group substance abuse therapy.

Physicians interested in providing substance abuse should refer to service-specific Medicaid publications, which may be downloaded from the Medicaid Web site or obtained by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Telemedicine

Telemedicine is the use of telecommunications technology for diagnostic, monitoring, and medical education purposes. Wisconsin Medicaid does not cover telemedicine services.

Weight Management Services

Weight management services (e.g., diet clinics, obesity programs, weight loss programs) are reimbursable only if performed by or under the direct, on-site supervision of a physician and if performed in a physician's office. Weight management services exceeding five visits per calendar year require PA. Prescription drugs prescribed for weight loss also require PA. (Refer to the Pharmacy Handbook for additional information about prescription drug PA requirements.)

Submit claims for weight management services with the appropriate E&M procedure code. For weight management services, food supplements and dietary supplies (e.g., liquid or powdered diet foods or supplements, OTC diet pills, and vitamins) that are dispensed during an office visit are not separately reimbursable by Wisconsin Medicaid.

Wisconsin Medicaid does not cover telemedicine services.

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Surgery Services

Abortions

Coverage Policy

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

The optional Abortion Certification Statements form, HCF 1161, is located in Appendix 10 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site. Providers may develop a form of their own, as long as it includes the same information.

Covered Services

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services. Wisconsin Medicaid covers treatment for

complications arising from an abortion, regardless whether the abortion itself is a covered service, because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

Coverage of Mifeprex

Wisconsin Medicaid reimburses for Mifeprex under the same coverage policy that it reimburses other surgical or medical abortion procedures under s. 20.927, Wis. Stats.

When submitting claims for Mifeprex, providers are required to:

- Use the Healthcare Common Procedure Coding System (HCPCS) code S0190 (Mifepristone, oral, 200 mg) for the first dose of Mifeprex, along with the evaluation and management (E&M) code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- Use the HCPCS code S0191 (Misoprostol, oral, 200 mcg), for the drug given during the second visit, along with the E&M code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) abortion diagnosis code with each claim submission.
- Attach to each claim a completed abortion certification statement that includes information showing the situation is one in which Wisconsin Medicaid covers the abortion. The optional Abortion Certification Statements form is located in

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services.

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Appendix 10 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

Note: Wisconsin Medicaid denies claims for Mifeprex reimbursement when billed with a National Drug Code.

Physician Counseling Visits Under s. 253.10, Wis. Stats.

Section 253.10, Wis. Stats., provides that a woman's consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute.

Pursuant to this statute, the Department of Health and Family Services has issued preprinted material summarizing the statutory requirements and a patient consent form. Copies of these materials may be obtained by writing to the following address:

Administrator
Division of Public Health
PO Box 2659
Madison WI 53701-2659

Wisconsin Medicaid will cover an office visit during which a physician provides the information required by this statute.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Anesthesia services.
- Laboratory testing and interpretation.
- Recovery room services.
- Transportation.
- Routine follow-up visits.
- Ultrasound services.

Anesthesia by Surgeon

Reimbursement for anesthesia provided by the surgeon (e.g., local infiltration, digital block, conscious sedation, topical anesthesia, regional anesthesia, and general anesthesia) is included in the Medicaid reimbursement for the surgical or diagnostic procedure(s) performed and is not separately reimbursable.

However, if the anesthesia is the primary procedure performed, for diagnosis or treatment, it is separately reimbursable. For example, if an intercostal nerve block is done for diagnosis and treatment of post-therapeutic neuralgia, and an epidural steroid injection procedure is also done, the anesthetic procedure is separately reimbursable.

Refer to the Anesthesia section of this handbook for more information.

Bariatric Surgery

All bariatric surgery procedures require PA.

The approval criteria for PA requests for Medicaid-covered bariatric surgery procedures include *all* of the following:

- The recipient must have one of the following:
 - ✓ A body mass index (BMI) of 40 or greater, or
 - ✓ A BMI of between 35 and 39 with documented high-risk, comorbid medical conditions that have not responded to medical management and are a threat to life (e.g., clinically significant obstructive sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy, coronary heart disease, medically refractory hypertension, or severe diabetes mellitus), and
- The recipient must have attempted weight loss in the past without successful long-term weight reduction. These attempts may include, but are not limited to, diet restrictions/supplements, behavior modification, physician-supervised weight

All bariatric surgery procedures require PA.

Breast reconstruction requires PA; however, PA is *waived* for breast reconstruction when performed following a mastectomy for breast cancer.

loss plans, physical activity programs, commercial or professional programs, or pharmacological therapy.

- The prior authorization (PA) request must include clinically documented evidence of all of the following:
 - ✓ A minimum of six months of demonstrated adherence by the recipient to a physician-supervised weight management program with at least three consecutive months of participation in this program prior to the date of surgery in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the recipient's ability to comply with postoperative medical care and dietary restrictions. Supporting documentation must include a physician's assessment of the recipient's participation and progress throughout the course of the program. A physician's summary letter is not sufficient supporting clinical documentation.
 - ✓ Agreement by the recipient to attend a medically supervised postoperative weight management program for a minimum of six months for the purpose of ongoing dietary, physical activity, behavioral/psychological, and medical education and monitoring.
- The recipient must receive a preoperative evaluation by an experienced and knowledgeable multi-disciplinary bariatric treatment team composed of health care providers with medical, nutritional, and psychological experience. This evaluation must include all of the following:
 - ✓ A complete history and physical examination, specifically evaluating for obesity-related comorbidities that would require preoperative management.
 - ✓ Evaluation for any correctable endocrinopathy that might contribute to obesity.
 - ✓ Dietary assessment and counseling.
 - ✓ Psychological/psychiatric evaluation and clearance to determine the

stability of the recipient in terms of tolerating the operative procedure and postoperative sequelae, as well as the likelihood of the recipient participating in an ongoing weight management program following surgery. Recipients receiving active treatment for a psychiatric disorder should receive evaluation by their treatment provider prior to bariatric surgery and be cleared for bariatric surgery.

- The recipient must be 18 years of age or older and have completed growth.

All of the following must be included in the PA request:

- A completed Prior Authorization Request Form (PA/RP), HCF 11018.
- A completed Prior Authorization/Physician Attachment (PA/PA), HCF 11016.
- Clinical documentation supporting the criteria.

The following procedures are considered investigational, inadequately studied, or unsafe and therefore are not covered by Wisconsin Medicaid:

- Gastric balloon.
- Biliopancreatic bypass.
- Loop gastric bypass.

Breast Reconstruction

Breast reconstruction requires PA; however, PA is *waived* for breast reconstruction when performed following a mastectomy for breast cancer. (Breast reconstruction is identified by *Current Procedural Terminology* [CPT] codes 19316-19325, 19340-19350, 19357-19369, 19380-19396.) This is pursuant to the federal Women's Health and Cancer Rights Act of 1998. Claims for breast reconstruction must include an ICD-9-CM diagnosis code for breast cancer (174.0-174.9, 175.0-175.9, 233.0, 238.3, 239.3) in order for the PA requirement to be waived by Wisconsin Medicaid.

Cataract Surgery

When a surgeon performs all of the components of cataract surgery, including preoperative, surgical, and postoperative care, the appropriate surgical procedure code should be indicated on the claim. Providers should follow the guidelines outlined in this chapter if another physician or an optometrist performs postoperative care.

Surgical Care Only

Submitting claims for surgical care only is allowed when one surgeon performs the cataract surgery and another provider delivers postoperative management. Surgical care only is identified by adding modifier “54” (Surgical care only) to the appropriate procedure code on the claim. Refer to the Appendix 1 of this section for applicable cataract surgery procedure codes that can be reimbursed with modifier “54.” Wisconsin Medicaid does not separately reimburse surgical care (modifier “54”) for any other surgical procedure codes.

The following criteria apply when using modifier “54”:

- The modifier is allowable only for the surgeon who performed the surgery.
- The surgeon is reimbursed at 80 percent of the global maximum allowable fee for performing the surgery.
- Wisconsin Medicaid will not reimburse more than what the global period allows for a given surgery. The sum of reimbursement for separately performed “surgical care only” and “postoperative management only” will not exceed the global maximum allowable fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.
- Hospital inpatients: If cataract surgery is performed on a hospital inpatient, only the surgeon may submit claims for the appropriate cataract procedure codes with modifier “54.” Any other provider who sees the recipient during the inpatient stay will be reimbursed only for medically

necessary E&M procedures (e.g., 99232 [subsequent hospital care]).

Postoperative Management

Postoperative management for cataract surgery is allowed only when a physician or other qualified provider performs the postoperative management during the postoperative period after a different physician has performed the surgical procedure.

Modifier “55” (Postoperative management only) should be used with the appropriate cataract surgery procedure code when another provider delivers all or part of the postoperative management or when the surgeon provides a portion of the postoperative management. Refer to Appendix 1 of this section for cataract surgery procedure codes that can be reimbursed with modifier “55.” Wisconsin Medicaid does not separately reimburse postoperative management (modifier “55”) for any other surgical procedure codes.

The following criteria apply when using modifier “55”:

- Modifier “55” includes all postoperative visits performed by a provider. Quantity is limited to “1” per provider during the entire postoperative period.
- Wisconsin Medicaid will not reimburse more than the global maximum allowable fee for a given surgery, including postoperative management. The sum of reimbursement for separately performed “postoperative management only” and “surgical care only” will not exceed the global fee for cataract surgery, regardless of the number of providers involved. Reimbursement may be reconciled in post-pay audit.
- The provider is reimbursed at 20 percent of the global maximum allowable fee for providing postoperative management for major surgery.
- When two or more provider types (i.e., ophthalmologists, optometrists, or other qualified providers) split postoperative management, reimbursement will be

Modifier “55” (Postoperative management only) should be used with the appropriate cataract surgery procedure code when another provider delivers all or part of the postoperative management or when the surgeon provides a portion of the postoperative management.

The performing surgeon is required to obtain PA for the cochlear or bone-anchored hearing device implant surgeries.

reduced proportionately following post-pay review of the claims and/or medical records.

- The surgeon *and* all postoperative management providers are required to keep a copy of the written transfer agreement with the dates of relinquishment and assumption of care in their recipient's medical record.
- The dates that the postoperative management was provided as indicated on the claim must occur on and after those indicated on the transfer agreement. A claim with a DOS prior to what was indicated on the transfer agreement will be denied during post-pay review and the reimbursement will be recouped.
- Wisconsin Medicaid does not require providers to submit additional supporting clinical documentation as part of the claims submission process for cataract surgery.

Preoperative Management

Preoperative management is included in the reimbursement rate for surgical care and is not separately reimbursable. Wisconsin Medicaid does not separately reimburse modifier "56" (Preoperative management only) when submitting claims for preoperative management.

Cochlear Implants

The performing surgeon is required to obtain PA for the cochlear or bone-anchored hearing device implant surgeries. Wisconsin Medicaid will deny claims for services relating to the surgery unless there is an approved PA request on file from the performing surgeon for the surgery.

The surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center *and* the surgeon is Medicaid-certified as a medical equipment vendor.

Contraceptive Implants

Wisconsin Medicaid covers contraceptive implant devices (e.g., Norplant).

Reimbursement for the contraceptive implant CPT procedure codes 11975, 11976, or 11977 includes the E&M service, supplies, and the cost of the device.

Providers should not submit claims for E&M services and supplies associated with contraceptive implant services, unless another separate and distinct service is provided and documented in the recipient's medical record.

Informed Consent Procedure

Wisconsin Medicaid recommends that providers of implantable contraceptives have a fully informed consent procedure and present comprehensive information to recipients prior to the implantation procedure. This information should include the following:

- Physiological effects of contraceptive implants.
- Risks associated with implant use.
- Potential side effects.
- Recommendations for follow-up care and removal.

As part of the informed consent process, Wisconsin Medicaid recommends using information provided in the patient education materials supplied by the manufacturer. Recipients should be informed of the following considerations:

- Some patients may experience thick, permanent scarring of the skin at the insertion and removal site (keloid formation).
- Migration of the capsules may occur making removal difficult.
- Women can request the implant be removed at any time.
- The implant does not provide protection against sexually transmitted diseases.

Wisconsin Medicaid recommends providing a waiting period between the education session

and the insertion of the implant, as it may help ensure that a proper amount of time is allowed for an informed decision. Some providers indicate that this allows increased recipient acceptance of the implant. Such a waiting period may not always be acceptable, however, considering factors such as recipient preferences and limited transportation.

Informed Consent Documentation

Informed consent should be documented in the recipient's medical record and must include the signatures or initials of both the provider and the recipient.

Co-surgeons/Assistant Surgeons

Under certain circumstances, the expertise of two or more surgeons (usually, but not always, with different specialties) may be required and medically necessary in the management of specific surgical procedures. In these cases, both surgeons submit claims for the surgery code(s). Each surgeon is reimbursed at Wisconsin Medicaid's usual surgeon rate for the specific procedure he or she has performed. Attach additional supporting clinical documentation (such as an operative report) to each surgeon's paper claim to demonstrate medical necessity and to identify the co-surgeons.

When two or more surgeons perform one or more procedures that are generally performed by a surgeon and an assistant (or assistants), the principal surgeon submits a claim for the surgery procedure code(s) and the additional surgeon(s) submits a claim for the surgery procedure code(s) with modifier "80" (assistant surgeon).

When a physician assistant serves as an assistant to a surgery, modifier "80" should be indicated with the appropriate procedure code on the claim. Wisconsin Medicaid will automatically calculate the appropriate reimbursement based on the provider type performing the procedure.

Dilation and Curettage

Providers are required to submit a paper claim for dilation and curettage. The claim must include additional supporting clinical documentation such as a preoperative history or physical exam report.

Foot Care

Wisconsin Medicaid covers the cleaning, trimming, and cutting of toenails once every 31 days (for one or both feet) if the recipient has one of the following systemic conditions:

- Arteriosclerosis obliterans evidenced by claudication.
- Cerebral palsy.
- Diabetes mellitus.
- Peripheral neuropathies involving the feet, which are associated with one of the following:
 - ✓ Malnutrition or vitamin deficiency.
 - ✓ Carcinoma.
 - ✓ Diabetes mellitus.
 - ✓ Drugs and toxins.
 - ✓ Multiple sclerosis.
 - ✓ Uremia.

Unna Boots

The application of unna boots is reimbursable for recipients with one of the following diagnoses:

- Varicose veins of lower extremities.
- Venous insufficiency, unspecified.
- Chronic ulcer of skin.
- Decubitus or other ulcer of lower extremity.
- Edema of lower extremities.

Reimbursement for the cost of the unna boot is included in the reimbursement for the application procedure.

Hysterectomies

Wisconsin Medicaid does not cover a hysterectomy for uncomplicated fibroids, fallen uterus, or retroverted uterus.

When two or more surgeons perform one or more procedures that are generally performed by a surgeon and an assistant (or assistants), the principal surgeon submits a claim for the surgery procedure code(s) and the additional surgeon(s) submits a claim for the surgery procedure code(s) with modifier "80" (assistant surgeon).

Medicaid reimbursement for a hysterectomy requires the completion of the Acknowledgment of Receipt of Hysterectomy Information form or a similar form with the same information.

An Acknowledgment of Receipt of Hysterectomy Information form, HCF 1160, must be completed prior to the surgery and attached to the CMS 1500 paper claim form, except in the circumstances noted below. Providers may develop their own form as long as it includes all the same information as Wisconsin Medicaid's form. The Acknowledgment of Receipt of Hysterectomy Information form is located in Appendix 13 of this section and may also be downloaded and printed from the Medicaid Web site.

A hysterectomy may be covered *without* a valid acknowledgment form if one of the following circumstances applies:

- The recipient was already sterile. Sterility may include menopause. (The physician is required to state the cause of sterility in the recipient's medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive recipient eligibility and one of the following circumstances applied:
 - ✓ The recipient was informed before the surgery that the procedure would make her permanently incapable of reproducing.
 - ✓ The recipient was already sterile.
 - ✓ The recipient was in a life-threatening emergency situation which required a hysterectomy.

For all of the exceptions above, the physician is required to identify, in writing, the applicable circumstance and attach the signed and dated documentation to the paper claim. (A copy of the preoperative history/physical exam and operative report is usually sufficient.)

Medicaid reimbursement for a hysterectomy requires the completion of the Acknowledgment of Receipt of Hysterectomy Information form or a similar form with the same information. The form is not to be used for purposes of consent of sterilization. Wisconsin Medicaid does not cover hysterectomies for the purposes of sterilization.

Intrauterine Devices

Wisconsin Medicaid reimburses physicians separately for the intrauterine device (IUD) and IUD insertion and removal procedures. Reimbursement for the E&M office visit and necessary supplies are included in the reimbursement for the IUD insertion and removal procedures. Do not submit a claim for the E&M visit or the supplies unless another separate and distinct service is provided and documented in the recipient's medical record.

Obstetric Services

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 procedure code may be reimbursed (see "Delivery" for details).

Separate Obstetric Care Components

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

Note: A telephone call between a patient and a provider does not qualify as an office visit.

Antepartum Care

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

Providers should refer to Appendix 9 of this section for 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.

Occasionally, a provider may be unsure of whether a recipient has had previous antepartum care 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.

Reimbursement for antepartum care (procedure codes 99204 with modifier “TH,” 99213 with modifier “TH,” 59425, and 59426) is limited to once per pregnancy, per recipient, per billing provider.

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.

A provider who performs a vaginal or cesarean delivery may submit a claim using the appropriate delivery code. A clinic or group may submit a claim 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), one claim should be submitted for all of the deliveries. On the first detail line of the claim, 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.

In cases where surgical assistance is medically necessary for a cesarean delivery, both surgeons should submit a claim with the appropriate procedure code. Refer to “Co-surgeons/Assistant Surgeons” of this chapter for more information.

Induction or Inhibition of Labor

Pitocin drip and tocolytic infusions are not separately reimbursable when provided on the date of delivery. Induction or inhibition of labor are only reimbursable when physician services are documented in the medical record and when performed on dates other than the delivery date. Submit paper claims for the service indicating CPT code 59899 (Unlisted procedure, maternity care and delivery) with supporting clinical documentation attached.

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.

In accordance with the standards of the American College of Obstetricians and Gynecologists, Medicaid reimbursement for 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.

In accordance with the standards of the American College of Obstetricians and Gynecologists, Medicaid reimbursement for postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit.

When submitting claims for total OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service.

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 a patient and a provider does *not* qualify as a postpartum visit.

Delivery and Postpartum Care

Providers who perform both the delivery and postpartum care may submit claims with 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 recipient does not return for the postpartum visit, the provider is required to adjust the claim to reflect delivery only or the reimbursement will be recouped through an audit.

Global Obstetric Care

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

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

When submitting claims for total 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 is required to adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the patient’s medical record.

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 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.

Separately Covered Pregnancy-Related Services

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

- Administration of Rh immune globulin.
- Amniocentesis, chorionic villous sampling, and cordocentesis.
- Epidural anesthesia. (Refer to the Anesthesia section of this handbook for epidural anesthesia claims submission information.)
- External cephalic version.
- Fetal biophysical profiles.
- 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 “Sterilizations” for sterilization limitations.)
- Surgical complications of pregnancy (e.g., incompetent cervix, hernia repair, ovarian cyst, Bartholin cyst, ruptured uterus, or appendicitis).

Unusual Pregnancies

Providers treating recipients whose pregnancies require more than the typical number of antepartum or postpartum visits or result in complications during delivery may seek additional reimbursement by submitting an Adjustment/Reconsideration Request, HCF 13046, for the allowed claim. Include a copy of the medical record and/or delivery report specifying the medical reasons for the extraordinary number of antepartum or postpartum visits. Wisconsin Medicaid will review the materials and determine the appropriate level of reimbursement. The Adjustment/Reconsideration Request may be downloaded and printed from the Forms page of the Medicaid Web site.

Complications of Pregnancy

Complications of pregnancy or delivery, such as excessive bleeding, pregnancy-induced hypertension, toxemia, hyperemesis, premature (not-artificial) rupture of membranes, and other complications during the postpartum period may all be reported and reimbursed separately from obstetrical care. The nature of these complications should be fully documented in the recipient’s medical record.

Unrelated Conditions

Any E&M 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 may include:

- 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

Many OB procedure codes are eligible for the Health Professional Shortage Area (HPSA)-enhanced reimbursement. Submit claims with HPSA modifier “AQ” to receive a 50 percent bonus incentive. Refer to the Reimbursement chapter of this section for more information about HPSA-enhanced reimbursement.

Other Insurance/Private Pay Prior to Wisconsin Medicaid Eligibility

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 HMO or SSI MCO

Wisconsin Medicaid will reimburse the equivalent of one global OB fee per recipient, per delivery, per single provider or provider group, whether the provider receives the reimbursement through fee-for-service Medicaid or through a Medicaid HMO or SSI MCO.

A recipient who is initially eligible for fee-for-service Medicaid may enroll in a Medicaid MCO during her pregnancy and receive care from the same provider or clinic. In this case, the provider may be paid a global fee by the MCO after the provider receives payment from fee-for-service Medicaid for the antepartum care. If this is the case, the provider is required to submit an adjustment request to have the fee-for-service Medicaid payment recouped.

Many OB procedure codes are eligible for the Health Professional Shortage Area (HPSA)-enhanced reimbursement.

Physicians, nurse practitioners, and nurse midwives should submit a Newborn Report *only* if the mother is *not* enrolled in a Medicaid HMO and the birth occurs *outside* a hospital setting.

If the provider does not submit an adjustment request 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 MCO, 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 more than the global fee or the combined maximum allowable fee for the services if billed separately.

Newborn Reporting

Providers are required to indicate a newborn's Medicaid identification number on claims.

Providers may report babies born to Medicaid recipients by submitting a Newborn Report form, HCF 1165, to Wisconsin Medicaid.

Establishing a newborn's Medicaid eligibility results in better health outcomes and fewer delays in provider reimbursement. The Newborn Report form is located in Appendix 29 of this section and may also be downloaded and printed from the Medicaid Web site.

Providers without Internet access should call Provider Services at (800) 947-9627 or (608) 221-9883 to request a paper copy of the form. Questions about the form may also be directed to Provider Services.

Responsibility for Reporting

Hospitals, Medicaid HMOs, physicians, nurse practitioners, and nurse midwives may report babies born to Medicaid recipients by submitting a Wisconsin Medicaid Newborn Report to Wisconsin Medicaid. Providers may develop and use their own form that contains the same information as the Newborn Report.

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

HMO completes the form. If a mother is enrolled in a Medicaid HMO but has her baby outside the HMO network, the HMO is responsible for reporting the birth to Wisconsin Medicaid.

The Newborn Report should be submitted to Wisconsin Medicaid even in instances in which the baby is born alive but does not survive.

If the mother was *not* covered by Wisconsin Medicaid when the baby was born, she can apply for Medicaid retroactively. If her dates of eligibility include the date of the baby's birth, her baby can also receive retroactive and continuous eligibility for the first year of life.

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 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.

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 or not 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.
- 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/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.

- Once the mother notifies her worker and her child has received a Social Security number, a permanent Medicaid number is assigned to the child.

Providers with questions regarding newborn eligibility may contact Provider Services.

Newborn Screenings

Wisconsin Medicaid covers the cost of prepaid filter paper cards in addition to the laboratory handling fee for newborn screenings provided outside a hospital setting. Refer to the Laboratory and Radiology section of this handbook for more information.

Organ Transplants

Wisconsin Medicaid reimburses physicians and transplant centers (hospitals) for organ transplants when they are:

- Medically necessary.
- Prior authorized (with the exception of kidney and cornea transplants which do not require PA).
- Performed in an approved United Network for Organ Sharing (UNOS) transplant center. Refer to the Data page of the Organ Procurement and Transplantation Network Web site at www.optn.org/ for UNOS-approved organ transplant centers.

Prior to making a referral to an approved transplant center, Wisconsin Medicaid recommends that physicians verify that the transplant center currently accepts Wisconsin Medicaid recipient referrals and Medicaid reimbursement for the proposed transplant.

Prior Authorization Requirements

For all transplants requiring PA, the transplant center in which the transplant will occur is required to request PA, *not* the physician. The transplant center and the physician are encouraged to jointly complete the PA request.

In cases of multiple organ transplants where no single CPT code describes the procedure performed, indicate each individual procedure code, if available, on the PA request.

Physicians should *not* indicate the PA number on the claim for the transplant surgery.

Sterilizations

General Requirements

A sterilization is any surgical procedure performed with the *primary* purpose of rendering an individual permanently incapable of reproducing. The procedure may be performed in an “open” or laparoscopic manner. This does not include procedures that, while they may result in sterility, have a different purpose such as surgical removal of a cancerous uterus or cancerous testicles.

Providers should refer to the physician services maximum allowable fee schedule for allowable sterilization procedure codes.

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a Sterilization Informed Consent form, HCF 1164. There are no exceptions. Federal and state regulations require the following:

- The recipient is not an institutionalized individual.
- The recipient is at least 21 years old on the date the informed written consent is obtained.
- The recipient gives voluntary informed written consent for sterilization.
- The recipient is not a mentally incompetent individual. Wisconsin Medicaid defines a “mentally incompetent” individual as a

For all transplants requiring PA, the transplant center in which the transplant will occur is required to request PA, *not* the physician.

To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent form before *all* sterilizations in the event that the patient obtains Medicaid retroactive eligibility.

person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
 - ✓ In the case of premature delivery, the sterilization is performed at the time of premature delivery *and* written informed consent was given at least 30 days before the expected date of delivery *and* at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
 - ✓ The sterilization is performed during emergency abdominal surgery *and* at least 72 hours have passed since the recipient gave written informed consent for sterilization.

Sterilization Consent Form

A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form. Sterilization coverage requires accurate and thorough completion of the consent form. The physician is responsible for obtaining consent. Any corrections to the form must be signed and dated by the physician and/or recipient, as appropriate. The completion instructions, sample copy of the Sterilization Informed Consent form, and a copy of the form for photocopying are located in Appendices 11 and 12 of this section and may also be downloaded and printed from the Medicaid Web site.

Signatures and signature dates of the recipient, physician, and the person obtaining the consent are mandatory. Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.

To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent form before *all* sterilizations in the event that the patient obtains Medicaid retroactive eligibility.

The completed consent form must be attached to a paper CMS 1500 claim form to obtain reimbursement.

Temporomandibular Joint Surgery

Providers may submit claims for assessing temporomandibular joint (TMJ) dysfunction using an E&M visit procedure code. A TMJ office visit generally consists of the following for a recipient experiencing TMJ dysfunction:

- Comprehensive history.
- Detailed and extensive clinical examination.
- Diagnosis.
- Treatment planning.

Refer to Appendix 27 of this section for a list of TMJ procedure codes and TMJ evaluation programs.

A recipient must have received appropriate nonsurgical treatment that has not resolved or improved the recipient's condition to be considered eligible for TMJ surgery. Nonsurgical treatment may include the following:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

Prior Authorization Requirements

Wisconsin Medicaid requires PA for TMJ surgery. Before submitting a PA request for TMJ surgery, the recipient must be evaluated

by a multi-disciplinary TMJ evaluation program or clinic approved by the Division of Health Care Financing (DHCF). Refer to Appendix 27 of this section for a list of approved TMJ programs. The evaluation must be done by a facility not previously involved in the treatment of the recipient. The multi-disciplinary evaluation includes:

- A dental evaluation conducted by an oral/maxillofacial surgeon, orthodontist, or general practice dentist.
- A physical evaluation conducted by a physician knowledgeable of TMJ-related problems and treatment.
- A psychological evaluation conducted by a psychiatrist or psychologist.

The surgeon who will perform the TMJ surgery requests PA by using the PA/RF, the PA/PA, and supporting documentation, including, but not limited to:

- Documentation describing all prior nonsurgical treatments, treatment dates, and treatment outcomes.
- A copy of the multi-disciplinary evaluation.
- The type of surgical procedure being considered.

A PA request received without an attached multi-disciplinary evaluation will be returned so that an evaluation can be documented. Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

If a recipient is enrolled in a Medicaid HMO or SSI MCO, a multi-disciplinary evaluation and PA by Wisconsin Medicaid are not required. The Medicaid HMO or SSI MCO may require a multi-disciplinary evaluation and will be responsible for payment of all medical costs related to the evaluation.

In addition, the Medicaid HMO or SSI MCO (not Medicaid fee-for-service) is responsible for paying the cost of all related medical and hospital services. The Medicaid HMO or SSI MCO may, therefore, designate the facility where the surgery will be performed. Physicians are required to participate in or obtain a referral from the recipient's HMO or SSI MCO, since the HMO or SSI MCO is responsible for paying the cost of all services. Failure to obtain an HMO or SSI MCO referral may result in a denial of payment for services by the HMO or SSI MCO.

Vagal Nerve Stimulators

Performing surgeons are required to obtain PA from Wisconsin Medicaid for vagal nerve stimulator implant surgeries. Wisconsin Medicaid will deny claims for services relating to the surgery unless there is an approved PA request on file from the performing surgeon for the surgery. The surgeon may receive separate reimbursement for the device if the surgery is performed in an outpatient hospital or ambulatory surgery center *and* the surgeon is Medicaid-certified as a medical equipment vendor.

Performing surgeons are required to obtain PA from Wisconsin Medicaid for vagal nerve stimulator implant surgeries.

P Prescription Requirements

General Prescription Requirements

It is vital that prescribers provide adequate supporting clinical documentation for a pharmacy or other dispensing provider to fill a prescription. Except as otherwise provided in federal or state law, a prescription must be in writing or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed.
- The service required, if applicable.
- The date of issue of the prescription.
- The prescriber's name and address.
- The recipient's name and address.
- The prescriber's signature (if the prescriber writes the prescription) and date signed.
- The directions for use of the prescribed drug, item, or service.

For hospital and nursing home recipients, prescriptions must be entered into the medical and nursing charts and must include the previously listed information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills that are valid for shorter periods of time.

Drugs

Wisconsin Medicaid covers most legend and certain over-the-counter (OTC) drugs. (A legend drug is one whose outside package has the legend or phrase "Caution, Federal law prohibits dispensing without a prescription" printed on it.)

Medicaid coverage for some drugs may be restricted by one of the following categories:

- Preferred Drug List (PDL).
- Prior authorization (PA).
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age- and gender-restricted drugs.

Prescribers are encouraged to write prescriptions for drugs that do not have restrictions; however, processes are available to obtain reimbursement for medically necessary drugs that do have restrictions.

For the most current prescription drug information, refer to the Physician page of the Medicaid Web site at dhfs.wisconsin.gov/medicaid/physician_20/index.htm. Providers may also call Provider Services at (800) 947-9627 or (608) 221-9883 for more information.

Preferred Drug List

Most preferred drugs on the PDL do *not* require PA, although these drugs may have other restrictions (e.g., age, diagnosis). Non-preferred drugs require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the recipient, before prescribing a non-preferred drug.

Providers should refer to the Physician page of the Medicaid Web site for the most current Medicaid PDL.

Wisconsin Medicaid covers most legend and certain over-the-counter (OTC) drugs.

Prescriber Responsibilities for Non-Preferred Drugs

If a non-preferred drug is medically necessary, the prescriber is required to complete the appropriate Prior Authorization/Preferred Drug List (PA/PDL) form and submit it to the dispensing provider. The PA/PDL form allows the prescriber to document that the recipient meets one of the clinical criteria requirements for PA approval. The completion instructions and PA/PDL forms may be downloaded and printed from the Medicaid Web site. Providers may also call Provider Services to obtain a paper copy of the forms.

Clinical criteria for approval of a PA request for a non-preferred drug must include one of the following:

- A treatment failure with a preferred drug.
- A condition that prevents the use of a preferred drug(s).
- A clinically significant drug interaction with another medication and a preferred drug(s).
- An intolerable side effect experienced while the recipient is taking a preferred drug(s).

If the recipient's condition does not meet one of the clinical criterion, a paper PA request and peer-reviewed medical literature must be submitted to Wisconsin Medicaid, not the dispensing provider.

Prescribers are required to complete a new PA/PDL form for each non-preferred drug and provide enough clinical information so that dispensing providers can request and obtain PA both for new prescriptions and for refills on existing prescriptions for non-preferred drugs.

If a PA/PDL form is not sent to the dispensing provider for an existing prescription of a non-preferred drug or does not accompany a new prescription for a non-preferred drug, the dispensing provider must contact the prescriber to obtain a completed copy of the form.

Prescribers may choose to change the prescription to a preferred drug if medically appropriate for the recipient.

A completed PA/PDL form may be sent by mail or fax to the dispensing provider where the prescription will be filled, or the prescriber may send a completed copy of the form with the recipient to the dispensing provider. Prescribers should *not* send prescription drug PA forms directly to Wisconsin Medicaid. The dispensing provider will use the completed form to submit a PA request to Wisconsin Medicaid. Prescribers and dispensing providers are required to retain a completed copy of the form. Refer to the Forms page of the Medicaid Web site for PA/PDL forms.

Step Therapy for Proton Pump Inhibitor Drugs

Proton Pump Inhibitor (PPI) drugs on the PDL require step therapy. Step therapy requires that a recipient try and fail one or more preferred drugs before obtaining PA for a non-preferred drug. The preferred PPI drug is Prilosec OTC®.

Approval of a PA request for a non-preferred PPI drug can only occur in one of the following situations:

- The recipient has trial and failure of or adverse reaction to a preferred PPI drug.
- The recipient is a child weighing less than 20 kilograms (44 lbs).
- The recipient is a pregnant woman.

Refer to the Forms page of the Medicaid Web site for step therapy instructions for PPI drugs and the appropriate PA/PDL form.

Step Therapy for Non-Steroidal Anti-Inflammatory Drugs

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) on the PDL require the use of step therapy. Step therapy requires that a recipient

If a non-preferred drug is medically necessary, the prescriber is required to complete the appropriate Prior Authorization/Preferred Drug List (PA/PDL) form and submit it to the dispensing provider.

Wisconsin Medicaid requires PA for brand medically necessary legend drugs with available generic equivalents.

try and fail one or more preferred drugs before obtaining PA for a non-preferred drug.

Clinical criteria for approval of a non-preferred NSAID include the following:

- The trial and failure of or an adverse reaction to a preferred NSAID.
- Risk factors, including:
 - ✓ The recipient is over 65 years of age.
 - ✓ The recipient has a history of ulcers or gastrointestinal (GI) bleeding.
 - ✓ The recipient is currently taking anticoagulants.
- The recipient is receiving treatment for a chronic condition.

Providers should refer to the Forms page of the Medicaid Web site for step therapy instructions for NSAID and the appropriate PA/PDL form.

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those drugs that are diagnosis-restricted through Wisconsin Medicaid. Refer to Appendix 32 of this section or the Physician page of the Medicaid Web site for diagnosis-restricted drugs.

Brand Medically Necessary Drugs

Wisconsin Medicaid requires PA for brand medically necessary legend drugs with available generic equivalents. Refer to the Physician page of the Medicaid Web site for brand-name drugs that require PA.

Prescribers are required to do the following when prescribing brand medically necessary legend drugs:

- Write “Brand Medically Necessary” on the prescription. (Phrases like “No Substitutes” or “N.S.” are not acceptable.) This certification must be in the prescriber’s own handwriting and written directly on the prescription or on the face of each new prescription or on a separate order attached to the original prescription.

Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement.

- Complete a Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), HCF 11083. The completion instructions and PA/BMNA may be downloaded and printed from the Medicaid Web site. Providers may also call Provider Services to obtain a paper copy of the form. Documentation on the PA/BMNA must indicate how the brand-name drug will prevent recurrence of the adverse or allergic reaction or therapeutic failure.
- Submit the prescription and PA/BMNA to the pharmacy where the prescription will be filled. Prescribers should *not* send prescription drug PA forms directly to Wisconsin Medicaid. The pharmacy is required to complete the Prior Authorization Request Form (PA/RF), HCF 11018, and submit the PA/BMNA, the PA/RF, and a copy of the prescription to Wisconsin Medicaid.

Prescribers are required to submit a new PA/BMNA only when prescribing a new brand medically necessary drug. Pharmacies may contact prescribers to request that the prescriber complete the PA/BMNA if one has not already been completed.

A prescriber is required to document clinical criteria for prescribing the brand-name drug on the PA/BMNA. Criteria for approval of the brand-name drug include the following:

- An adverse reaction to the generic drug(s).
- An allergic reaction to the generic drug(s).
- Actual therapeutic failure of the generic drug(s).

Prescribers are required to retain a copy of the completed PA/BMNA and prescription in the recipient’s medical record.

Approval Criteria for Narrow Therapeutic Index Drugs

For certain narrow therapeutic index drugs, including Clozaril, Coumadin, Dilantin, Neoral and Tegretol, an additional criteria of an *anticipated* therapeutic failure is considered. Documentation on the PA/BMNA must include the prescriber's belief that switching the recipient to a generic drug is likely to cause an adverse reaction.

Titration of Brand Medically Necessary Drugs

Prescribers who titrate a brand medically necessary drug for a recipient may request more than one strength of the drug on the PA/BMNA. Prescribers should include a prescription for each strength of the titrated brand medically necessary drug with the PA/BMNA.

Prior Authorization Requirements for Other Drugs

Although pharmacies are responsible for obtaining PA for the following drugs that are on the brand medically necessary list or the PDL, prescribers (e.g., physicians, physician assistants, nurse practitioners) may be asked to provide clinical information to support the medical necessity of the drug(s):

- Alpha-1 proteinase inhibitor (Prolastin and Aralast).
- Angiotensin converting enzyme (ACE) inhibitors.
- Anti-obesity drugs.
- Brand-name selective serotonin reuptake inhibitor (SSRI) drugs. (Generic citalopram, fluoxetine, and paroxetine do not require PA.)
- C-III and C-IV stimulants.

Refer to the Medicaid Web site for more information about these and other drugs.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

Drug manufacturers who choose to participate in state Medicaid programs are required to sign a rebate agreement with the federal Centers for Medicare and Medicaid Services under the drug rebate program. By signing the rebate agreement, the manufacturer agrees to pay Wisconsin Medicaid a rebate equal to a percentage of its "sales" to Wisconsin Medicaid.

Wisconsin Medicaid does not cover drugs of companies choosing not to sign the rebate agreement with few exceptions. A Medicaid-certified pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement. In addition, providers may refer to the Physician page of the Medicaid Web site for a list of manufacturers who have signed drug rebate agreements.

Wisconsin Medicaid recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer who has not signed a rebate agreement. These drugs may be reimbursed when the *pharmacy* obtains PA.

In this situation, the *prescriber* is required to provide the following documentation to the pharmacy:

- A statement indicating that no other drug produced by a manufacturer who signed the rebate agreement is medically appropriate for the recipient.
- A statement indicating that Medicaid reimbursement of the drug would be cost effective for Wisconsin Medicaid.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber documenting medical necessity.

Wisconsin Medicaid does not cover drugs of companies choosing not to sign the rebate agreement with few exceptions.

Wisconsin Medicaid allows certain drugs to be prescribed and dispensed up to a maximum of a 100-day supply as stated in HFS 107.10(3)(e), Wis. Admin. Code.

Drug Utilization Review System

The federal Omnibus Budget Reconciliation Act of 1990 (42 CFR Parts 456.703 and 456.705) called for a Drug Utilization Review (DUR) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of recipient care. Wisconsin Medicaid's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. The DUR system checks the recipient's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a medical profile for each recipient. The prospective DUR system uses this profile to determine whether a prescribed drug may be inappropriate or harmful to the recipient. It is very important that prescribers provide up-to-date medical diagnosis information about recipients on medical claims to ensure complete and accurate recipient profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacist receives an alert, a response is required before the drug can be dispensed to the recipient. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled. Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs with 100-Day Supply Maximum

Wisconsin Medicaid allows certain drugs to be prescribed and dispensed up to a maximum of

a 100-day supply as stated in HFS 107.10(3)(e), Wis. Admin. Code. These drugs are:

- Digoxin, digitoxin, and digitalis.
- Hydrochlorothiazide and chlorothiazide.
- Prenatal vitamins.
- Fluoride.
- Levothyroxine, liothyronine, and thyroid extract.
- Phenobarbital.
- Phenytoin.
- Oral contraceptives.

The following drugs may also be made available in a supply of up to 100 days:

- Insulin.
- Generic oral hypoglycemic drugs.

Recipient Benefits

When it is appropriate for the recipient's medical condition, a 100-day supply of the previously listed drugs may be beneficial to the recipient by:

- Aiding compliance in taking prescribed medications.
- Reducing the cost of recipient copayments.
- Requiring fewer trips to the pharmacy.

Prescribers of these previously listed drugs are encouraged to write prescriptions for a 100-day supply when appropriate for the Medicaid recipient.

Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a 100-day supply. For example, if the prescription is written for "Phenytoin 100 mg., take one capsule three times daily," the dispensing provider may dispense up to 300 capsules as long as the

prescriber has indicated a 100-day supply quantity on the prescription.

Prescription Mail Delivery

Current Wisconsin law permits Wisconsin Medicaid-certified retail pharmacies to deliver prescriptions to recipients via the mail. Wisconsin Medicaid-certified retail pharmacies may dispense and mail any prescription or OTC medication to a Medicaid fee-for-service recipient at no additional cost to the recipient or Wisconsin Medicaid.

Providers are encouraged to use the mail delivery option if requested by the recipient, particularly for prescriptions filled for a 100-day supply.

Noncovered Drugs

The following drugs are not covered by Wisconsin Medicaid:

- Drugs that are identified by the Food and Drug Administration as less-than-effective (LTE) or identical, related, or similar to LTE drugs.
- Drugs identified on the Wisconsin Negative Formulary.
- Drugs manufactured by companies who have not signed the rebate agreement.

SeniorCare

Wisconsin SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. Wisconsin SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Wisconsin Medicaid, SeniorCare does not cover OTC drugs other than insulin. Refer to the SeniorCare section of the Pharmacy Handbook or the SeniorCare Web site at dhfs.wisconsin.gov/seniorcare/ for more information.

Epocrates

Providers may also access the Medicaid and SeniorCare PDL through Epocrates.

Epocrates' products provide clinical reference information specifically for health care providers to use at the point of care. Prescribers and dispensing providers (e.g., pharmacies, dispensing physicians, federally qualified health centers, blood banks) who use personal digital assistants can subscribe and download the PDL by accessing the Epocrates Web site at www2.epocrates.com/.

Disposable Medical Supplies and Durable Medical Equipment

All durable medical equipment (DME) and disposable medical supplies (DMS) require a physician or physician assistant prescription signed and dated by the prescriber except for the following DMS:

- Hearing instrument accessories.
- Hearing instrument batteries.
- Hearing instrument repairs.

Prescribers are reminded that they are required to determine that all DME and DMS items are medically necessary before a prescription is written. Refer to the medical supply provider and medical equipment vendor publications on the Medicaid Web site for more information on DMS and DME coverage and limitations.

Breast Pumps

Wisconsin Medicaid reimburses for the prescribing of breast pumps as part of an evaluation and management office visit. Physicians are required to document clinical requirements of an individual's need for a breast pump. Wisconsin Medicaid requires the following criteria be met:

- The recipient recently delivered a baby and a physician has ordered or recommended mother's breast milk for the infant.
- Documentation indicates there is the potential for adequate milk production.

Prescribers are reminded that they are required to determine that all DME and DMS items are medically necessary before a prescription is written.

Wisconsin Medicaid requires a prescription for specialized medical vehicle (SMV) trips that exceed Wisconsin Medicaid's one-way mileage limits.

- Documentation indicates there is a long-term need for and planned use of the breast pump to obtain a milk supply for the infant.
- The recipient is capable of being trained to use the breast pump as indicated by the physician or provider.
- Current or expected physical separation of mother and infant (e.g., illness, hospitalization, work) would make breastfeeding difficult, or there is difficulty with “latch on” due to physical, emotional, or developmental problems of the mother or infant.

The optional Breast Pump Order, HCF 1153, is located in Appendix 14 of this section and may also be downloaded and printed from the Medicaid Web site.

Physicians or nurse practitioners may prescribe breast pumps for recipients that can then be obtained through a Medicaid-certified DME provider or pharmacy. Wisconsin Medicaid does not reimburse prescribing providers for supplying breast pumps, unless they are also Medicaid certified as a medical equipment vendor or a pharmacy.

Specialized Medical Vehicle Trips Exceeding Mileage Limits

Wisconsin Medicaid requires a prescription for specialized medical vehicle (SMV) trips that exceed Wisconsin Medicaid's one-way mileage limits. In addition to a prescription, a completed Certification of Need for Specialized Medical Vehicle Transportation

form, HCF 1197, is also required. The completion instructions and Certification of Need for Specialized Medical Vehicle Transportation form are located in Appendix 28 of this section and may also be downloaded and printed from the Medicaid Web site. A medical care provider referring an SMV-eligible recipient to a Medicaid-covered health service that is farther than the upper mileage limit must write a prescription for the recipient to give to the SMV provider.

Wisconsin Medicaid one-way upper mileage limits are:

- 40 miles or more, if the trip originates in one of these urban counties:

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

The prescription must be renewed upon expiration and must include the following:

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

For more information about SMV services, refer to the General Information chapter of this section.

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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).

This chapter includes claims submission information for physician services providers. 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.

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.

All claims that providers submit, whether submitted using the 837 Health Care Claim: Professional (837P) transaction or paper, are subject to the same Medicaid processing and legal requirements.

837 Health Care Claim: Professional

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for physician services may be submitted using the 837P transaction *except* when billing an “unlisted” (nonspecific) procedure code or when additional supporting documentation must be submitted with the claim.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

CMS 1500

Paper claims for physician services must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for physician services submitted on any paper claim form other than the CMS 1500 claim form. A paper claim must be submitted when billing for an “unlisted” (nonspecific) procedure code(s) or when additional supporting documentation must be submitted with the claim. Examples of physician services that must be submitted on the CMS 1500 claim form include:

- Synagis® for children older than 2 years old.
- Physician-administered drugs that are not on the physician services maximum allowable fee schedule or unclassified drugs that do not require prior authorization.
- Surgeries performed by cosurgeons.
- Anesthesia services with a quantity greater than 30.
- Sterilizations, abortions, hysterectomies.

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

Refer to Appendix 4 of this section for CMS 1500 claim form completion instructions. Refer to Appendices 5, 6, 7, and 8 for completed sample CMS 1500 claim forms for physician services.

Adjustments

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to Wisconsin Medicaid. Refer to the Claims Information section of the All-Provider Handbook for more information about adjustment requests. Examples of when physician services providers may submit an

adjustment request include, but are not limited to, the following:

- Critical care and prolonged services lasting longer than six hours.
- Emergency room services with unique circumstances or unusually high complexity.
- Obstetrical services with an unusually high number of antepartum or postpartum care visits or complications.

Unlisted Procedures

Claims for services identified by unlisted (nonspecific) procedure codes must be submitted on paper because a national standard for electronic claim attachments has not been established at this time. To receive reimbursement for a service identified by an unlisted procedure code, a description of the service must be indicated in Element 19 of the paper claim. If Element 19 does not provide enough space for the description, or if a provider is billing multiple unlisted procedure codes, documentation may be attached to the claim. In this instance, the provider should indicate “see attachment” in Element 19.

The description in Element 19 or the documentation attached to the claim must be sufficient to allow Wisconsin Medicaid to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in Wisconsin Administrative Code.

ClaimCheck Review

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to *Current Procedural Terminology* (CPT) codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

ClaimCheck monitors the following Medicaid policy areas:

1. *Unbundling (Code Splitting)*

Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. ClaimCheck considers the single, most appropriate code for reimbursement when unbundling is detected.

If a provider submits a claim for certain procedure codes separately, ClaimCheck rebundles them into the single, most appropriate panel. For example, if a provider submits a claim with two procedure codes for layer closure of wounds, 12.6 cm to 20.0 cm and 20.1 cm to 30.0 cm (procedure codes 12035 and 12036), ClaimCheck rebundles them to layer closure of wounds over 30.0 cm (procedure code 12037).

ClaimCheck totals billed amounts for individual procedures. For example, if a provider submits a claim for three procedures at \$20, \$30, and \$25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at \$75. However, Wisconsin Medicaid reimburses the provider either the lesser of the billed amount or the maximum allowable fee for that procedure code.

2. *Incidental/Integral Procedures*

Incidental procedures are those procedures performed at the same time as a more complex primary procedure. They

Claims for services identified by unlisted (nonspecific) procedure codes must be submitted on paper because a national standard for electronic claim attachments has not been established at this time.

Integral procedures are those procedures performed as part of a more complex primary procedure.

require few additional physician resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during a hysterectomy surgery.

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a recipient undergoes a transurethral incision of the prostate (procedure code 52000), the cystourethroscopy is considered integral to the performance of the prostate procedure.

When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

3. **Mutually Exclusive Procedures**
Mutually exclusive procedures are procedures that would not be performed on a single recipient during the same operative session or that use different codes to describe the same type of procedure.

For example, a vaginal hysterectomy (procedure code 58260) and a total abdominal hysterectomy (procedure code 58150) are mutually exclusive — either one or the other procedure is performed, but not both.

When two or more procedures are mutually exclusive, Wisconsin Medicaid reimburses the procedure code with the highest provider-billed amount.

If circumstances warrant an exception, submit an Adjustment/Reconsideration Request, HCF 13046, with supporting documentation and the words “medical consultant review requested” written on the request. The completion instructions and Adjustment/Reconsideration Request are located in the Claims Information section of the All-Provider Handbook and may also be downloaded and printed from the Medicaid Web site.

Why Was Payment for a Service Denied by ClaimCheck?

Providers should take the following steps if they are uncertain about why particular services on a claim were denied:

1. Review Medicaid remittance information for the specific reason for the denial.
2. Review the claim submitted to ensure all information is accurate and complete.
3. Consult current CPT and Healthcare Common Procedure Coding System publications to make sure proper coding instructions were followed.
4. Consult this section and other current Wisconsin Medicaid publications to make sure current policy and billing instructions were followed.
5. Call Provider Services at (800) 947-9627 or (608) 221-9883 for further information or explanation.
6. If circumstances warrant an exception, submit an Adjustment Reconsideration/Request with supporting documentation and the words “medical consultant review requested” written on the form.

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Reimbursement

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. Physician services providers may obtain a maximum allowable fee schedule that contains reimbursement rates from one of the following sources:

- An electronic version on the Medicaid Web site.
- A paper copy, which may be purchased by doing either of the following:
 - ✓ Calling Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.
 - ✓ Writing to the following address:

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

Maximum Daily Reimbursement

A physician services provider's reimbursement for all services performed on the same date of service (DOS) for the same recipient may not exceed the amount established by Wisconsin Medicaid. As of July 1, 2002, the maximum daily reimbursement amount is \$2,308.43. The maximum daily reimbursement amount does not apply to the following:

- Physician-administered drugs.
- Durable medical equipment.

Medicaid remittance information will indicate when the maximum daily reimbursement amount has been met.

Surgery Services Exceeding Six Hours

A provider may request additional reimbursement for a surgery exceeding six hours. A provider in this situation should submit a claim in the usual manner. Additional reimbursement may be requested for the allowed claim by submitting an Adjustment/Reconsideration Request, HCF 13046, with clinical documentation. The completion instructions and Adjustment/Reconsideration Request are located in the Claims Information section of the All-Provider Handbook and may also be downloaded and printed from the Medicaid Web site.

Reimbursement Amounts

Physicians

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

Supervising Physicians of Interns and Residents

Wisconsin Medicaid reimburses supervising physicians in a teaching setting for the services provided by interns and residents, if those services are supervised, provided as part of the training program, and billed under the supervising physician's provider number. The supervising physician must provide personal and identifiable direction to interns or residents who are participating in the care of the recipient. This direction includes any or all of the following:

- Reviewing the recipient's medical history or physical examination.
- Personally examining the recipient within a reasonable period after admission.

- Confirming or revising diagnoses.
- Determining the course of treatment to be followed.
- Making frequent review of the recipient's progress.

The notes must indicate that the supervising physician personally reviewed the recipient's medical history, performed a physical and/or psychiatric examination, confirmed or revised the diagnosis, and discharged the recipient.

Residents

Wisconsin Medicaid reimburses residents for physician services when:

- The resident is fully licensed to practice medicine and has obtained a Medicaid provider number.
- The service can be separately identified from those services that are required as part of the training program.
- The resident is operating independently and not under the direct supervision of a physician.
- The service is provided in a clinic, an outpatient hospital, or emergency department setting.

The reimbursement for residents is identical to other licensed physicians.

Physician Assistants

Wisconsin Medicaid generally reimburses physician assistants 90 percent of the payment allowed for the physician who would have otherwise performed the service. Physician assistants are paid 100 percent of the physician's maximum fee for HealthCheck screens, injections, immunizations, lab handling fees, and select diagnostic procedures.

Nurse Practitioners

Nurse practitioners receive the same reimbursement as physicians for services.

Ancillary Providers

Wisconsin Medicaid covers counseling services (e.g., weight management, diabetic, smoking cessation, and prenatal services), coordination of care services, and delegated medical acts (e.g., giving injections or immunizations, checking medications, changing dressings) provided by ancillary providers if all of the following are true:

- The services are provided under the *direct, immediate, on-site* supervision of a physician.
- The services are pursuant to the physician's plan of care.
- The supervising physician has not also provided Medicaid reimbursable services during the same office or outpatient evaluation and management (E&M) visit.

Examples of ancillary providers include non-Medicaid certifiable health care professionals such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners. (Nurse practitioners, nurse midwives, and anesthesiologists who are Medicaid certified should refer to their service-specific Medicaid publications for billing information.)

"On-site" means that 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. The physician is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Since ancillary providers are not Medicaid-eligible providers, claims for these services must be submitted under the supervising physician's Medicaid provider number using the lowest appropriate level office or outpatient visit procedure code or other appropriate *Current Procedural Terminology* (CPT) code for the service performed. These services are not to be billed in addition to or combined with the physician service if the physician sees the patient during the same visit.

Wisconsin Medicaid generally reimburses physician assistants 90 percent of the payment allowed for the physician who would have otherwise performed the service.

Surgical Procedures

Surgical procedures performed by the same physician, for the same recipient, on the same DOS must be submitted on the same claim form. Surgeries that are billed on separate claim forms are denied.

Reimbursement for most surgical procedures includes reimbursement for preoperative and postoperative care days. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

Although E&M services pertaining to the surgery for DOS during the preoperative and postoperative care days are not covered, an E&M service may be reimbursed if it was provided in response to a different diagnosis.

Co-surgeons

Wisconsin Medicaid reimburses each surgeon at 100 percent of Wisconsin Medicaid's usual surgeon rate for the specific procedure he or she has performed. Attach supporting clinical documentation (such as an operative report) clearly marked "co-surgeon" to each surgeon's paper claim to demonstrate medical necessity.

Surgical Assistance

Wisconsin Medicaid reimburses for surgical assistance at 20 percent of the maximum allowable fee for the surgical procedure. To receive reimbursement for surgical assistance, indicate the surgery procedure code with modifier "80" (assistant surgeon) on the claim. Wisconsin Medicaid reimburses surgical assistance only for those surgeries that are listed in the physician fee schedule with modifier "80."

Physician assistants performing surgical assistance receive 90 percent of the maximum allowable fee for the surgery (with modifier "80").

Bilateral Surgeries

Bilateral surgical procedures are paid at 150 percent of the maximum allowable fee for the single service. Indicate modifier "50" (bilateral procedure) and a quantity of 1.0 on the claim.

Multiple Surgeries

Multiple surgical procedures performed by the same physician for the same recipient during the same surgical session are reimbursed at 100 percent of the maximum allowable fee for the primary procedure, 50 percent for the secondary procedure, 25 percent for the tertiary procedure, and 13 percent for all subsequent procedures. The Medicaid-allowed surgery with the greatest usual and customary charge on the claim is reimbursed as the primary surgical procedure, the next highest is the secondary surgical procedure, etc.

Wisconsin Medicaid permits full maximum allowable payments for surgeries that are performed on the same DOS but at *different* surgical sessions. For example, if a provider performs a sterilization on the same DOS as a delivery, the provider may be reimbursed the full maximum allowable fee for both procedures if performed at different times (and if all of the billing requirements were met for the sterilization).

To obtain full reimbursement, submit a claim for all the surgeries performed on the same DOS that are being billed for the recipient. Then submit an Adjustment/Reconsideration Request for the allowed claim with additional supporting documentation clarifying that the surgeries were performed in separate surgical sessions. Refer to the Medicaid Web site for a copy of the Adjustment/Reconsideration Request.

Note: Most diagnostic and certain vascular injection and radiological procedures are not subject to the multiple surgery reimbursement limits. Call Provider Services at (800) 947-9627 or (608) 221-9883 for more information

Surgical procedures performed by the same physician, for the same recipient, on the same DOS, must be submitted on the same claim form.

about whether a specific procedure code is subject to these reimbursement limits.

Multiple Births

Reimbursement for multiple births is dependent on the circumstances of the deliveries. If all deliveries are vaginal or if all are Cesarean, the first delivery is reimbursed at 100 percent of Medicaid's maximum allowable fee for the service. The second delivery is reimbursed at 50 percent, the third at 25 percent, and subsequent deliveries at 13 percent each.

In the event of a combination of vaginal and Cesarean deliveries, the delivery with the largest billed amount is reimbursed at 100 percent, the delivery with the next largest at 50 percent, and so on, consistent with the policy for other situations of multiple surgeries.

For example, if the initial delivery of triplets is vaginal and the subsequent two deliveries are Cesarean, the first Cesarean delivery is reimbursed at 100 percent, the second Cesarean delivery at 50 percent, and the vaginal delivery at 25 percent.

Preoperative and Postoperative Care

Reimbursement for certain surgical procedures includes the preoperative and postoperative care days associated with that procedure. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

Note: Separate reimbursement is allowed for postoperative management when it is performed by a provider other than the surgeon or shared with the surgeon following cataract surgery. Refer to the Surgery Services chapter of this section for more information on cataract surgery.

All primary surgeons, surgical assistants, and co-surgeons are subject to the same preoperative and postoperative care limitations for each procedure. For surgical services in which a preoperative period applies, the preoperative period is typically three days. Claims for services which fall within the range of established pre- and postcare days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure.

For the number of preoperative and postoperative care days applied to a specific procedure code, call Provider Services.

HealthCheck Services

Wisconsin Medicaid provides enhanced reimbursement for comprehensive health screenings for recipients under age 21 when those screenings are billed as HealthCheck services (CPT procedure codes 99381-99385 and 99391-99395).

Pediatric Services

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for recipients 18 years of age and under. The enhanced reimbursement rates are indicated on the physician fee schedule.

To obtain the enhanced reimbursement for recipients under 18 years old, indicate one of the applicable procedure codes and the modifier "TJ" (Program group, child and/or adolescent) on the claim.

Health Professional Shortage Areas

Wisconsin Medicaid provides enhanced reimbursement to Medicaid-certified primary care providers and emergency medicine

For the number of preoperative and postoperative care days applied to a specific procedure code, call Provider Services.

providers for selected services when one or both of the following apply:

- The performing or billing provider is located in a Health Professional Shortage Area (HPSA)-eligible ZIP code.
- The recipient has a residential address (according to Medicaid's eligibility records) within a HPSA-eligible ZIP code.

Primary care providers and emergency medicine providers include the following:

- Physicians with specialties of general practice, obstetrics and gynecology, family practice, internal medicine, or pediatrics.
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.

Standard enhanced reimbursement for HPSA-eligible primary care procedures is an additional 20 percent of the physician maximum allowable fee. The enhanced reimbursement for HPSA-eligible obstetrical procedures is an additional 50 percent of the physician maximum allowable fee.

Refer to Appendix 25 of this section for a list of HPSA-eligible procedure codes and ZIP codes.

Modifier

To obtain the HPSA-enhanced reimbursement, indicate modifier “AQ” (Physician providing a service in a HPSA) along with the appropriate procedure code on the claim.

Medicare HPSA policy differs from Wisconsin Medicaid's HPSA policy in many ways. Wisconsin Medicaid covers more services than *Medicare*, allows a broader range of providers to receive the incentive payment, pays a higher bonus, and defines HPSA differently than *Medicare*. Most importantly, Wisconsin Medicaid pays the enhanced reimbursement to physicians, physician assistants, nurse practitioners, and nurse midwives while *Medicare* pays the HPSA incentive payment only to physicians.

For these reasons, Medicare crossover claims that are eligible for Wisconsin Medicaid's HPSA incentive payment may not automatically be forwarded to Wisconsin Medicaid from *Medicare*. Providers may have to submit these claims directly to Wisconsin Medicaid.

Antepartum Care Visits Performed in a Health Professional Shortage Area

If only the first three antepartum care visits are being billed and the service is HPSA-eligible, the provider should bill the appropriate E&M code (99204 or 99213) with the “TH” modifier (Obstetrical treatment/services, prenatal or postpartum) listed first and the HPSA modifier listed second. Claims without modifier “TH” will result in lower reimbursement.

Pediatric Services Performed in a Health Professional Shortage Area

Reimbursement for eligible procedure codes with the HPSA modifier automatically includes the pediatric incentive payment, when applicable, since the incentive payment is based on the age of the recipient. Do not submit claims with the “TJ” modifier (Program group, child and/or adolescent) in addition to the HPSA modifier for the same procedure code. The “TJ” modifier may be used when submitting claims for eligible services in situations that do not qualify for HPSA-enhanced reimbursement. Pediatric services include office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for recipients 18 years and younger.

HealthCheck Services Not Eligible for Health Professional Shortage Area Incentive Payment

Procedure codes 99381-99385 and 99391-99395 are *not* eligible for HPSA bonuses, regardless of the billing or performing provider's or recipient's location, since reimbursement for these procedure codes includes enhanced reimbursement for HealthCheck services.

Standard enhanced reimbursement for HPSA-eligible primary care procedures is an additional 20 percent of the physician maximum allowable fee.

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Appendix 1

Allowable Procedure Codes and Modifiers for Physician Evaluation and Management, Medicine, and Surgical Services

The following table lists allowable *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes and modifiers for physician evaluation and management, medicine, and surgery services. These codes are updated on a quarterly basis. Consult the physician maximum allowable fee schedule or call Provider Services at (800) 947-9627 or (608) 221-9883, for the most current procedure codes and allowable modifier combinations. Refer to Appendix 2 of this section for modifier descriptions and Appendix 25 of this section for Health Professional Shortage Area-eligible procedure codes and ZIP codes.

Evaluation and Management Services		
Service	CPT Procedure Code(s)	Allowable Modifier(s)
Office or Other Outpatient Services	99201-99203	TJ
	99204	TH*, TJ
	99205	TJ
	99211-99212	TJ
	99213	TH*, TJ
	99214-99215	TJ
Hospital Observation Services	99217-99220	
Hospital Inpatient Services	99221-99239	
Consultations	99241-99275	
Emergency Department Services	99281-99285	TJ
	99288	
Critical Care Services	99291-99292	
Neonatal Intensive Care	99295-99298	
Nursing Facility Services	99301-99316	
Domiciliary, Rest Home, or Custodial Care Services	99321-99333	
Home Services	99341-99350	
Prolonged Services	99354-99357, 99360	
Preventive Medicine Services	99381-99397, 99429	
Newborn Care	99431-99440	
Unlisted Evaluation and Management Service	99499	
<p>*Providers are required to use modifier "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both modifiers "TH" and Health Professional Shortage Area (HPSA) modifier "AQ" when these prenatal services are HPSA eligible for appropriate reimbursement.</p>		
Anesthesia Services		
Refer to the Anesthesia section of this handbook for Medicaid-covered anesthesia services (CPT procedure codes 00100-01999).		

Appendix 1 (Continued)

Surgery Services

Service	CPT Procedure Code(s)	Allowable Modifier(s)
General	10021-10022	
Integumentary System	10040-19499	
Musculoskeletal System	20000-29999	
Respiratory System	30000-32999	
Cardiovascular System	33010-37799	
Hemic and Lymphatic Systems	38100-38999	
Mediastinum and Diaphragm	39000-39599	
Digestive System	40490-49999	
Urinary System	50010-51720	
	51725-51797	TC, 26
	51798-53899	
Male Genital System	54000-54235	
	54240, 54250	TC, 26
	54300-55899	
Female Genital System	56405-58999	
Maternity Care and Delivery	59000-59899	
Endocrine System	60000-60699	
Nervous System	61000-62230	
	62252	TC, 26
	62256-62365	
	62367, 62368	26
	63001-64999	
Eye and Ocular Adnexa	65091-66983	
	66820-66821, 66830-66984	54, 55
	66985-68899	
Auditory System	69000-69979	

Radiology Services

Refer to the Laboratory and Radiology section of this handbook for Medicaid-covered radiology services (CPT codes **70010-79999** and HCPCS codes).

Laboratory Services

Refer to the Laboratory and Radiology section of this handbook for Medicaid-covered laboratory services (CPT codes **80048-89356** and HCPCS).

Appendix 1 (Continued)

Medicine Services		
Service	CPT Procedure Code(s)	Allowable Modifier(s)
Immune Globulins	90281-90399	
Vaccines, Toxoids	90476-90749	
Therapeutic or Diagnostic Infusions	90780-90781	
Therapeutic, Prophylactic or Diagnostic Injections	90782-90799	
Psychiatry	90862	
	Refer to the mental health and substance abuse publications for covered services and related limitations for information on other psychiatric services coverage.	
Biofeedback	90901-90911	
Dialysis	90935-90999	
Gastroenterology	91000-91122	TC, 26
	91123	
	91132, 91133, 91299	TC, 26
Ophthalmology	Refer to the vision care services publications for more information about covered services and related limitations.	
	92002-92020	
	92060-92065	TC, 26
	92070	
	92081-92083	TC, 26
	92100, 92120, 92130	
	92135-92136	TC, 26
	92140-92230	
	92235-92250	TC, 26
	92260	
	92265-92286	TC, 26
	92287	
	92499	TC, 26
Special Otorhinolaryngologic Services	92502-92526	
	92531-92548	TC, 26
	92551-92584	
	92585-92588	TC, 26
	92590-92593	
	92601-92606	TC, 26
	92607-92611	
	92612-92615	TC, 26
	92616	

Appendix 1 (Continued)

Medicine Services (Continued)		
Service	CPT Procedure Code(s)	Allowable Modifier(s)
Special Otorhinolaryngologic Services (Continued)	92617	TC, 26
	92620-92625	
	92700	TC, 26
Cardiovascular	92950-92977	
	92978-92979	TC, 26
	92980-93018	
	93024-93025	TC, 26
	93040-93272	
	93278-93312	TC, 26
	93313	
	93314, 93315	TC, 26
	93316	
	93317-93318	26
	93320-93501	TC, 26
	93503	
	93505-93533	TC, 26
	93539-93545	
	93555-93572	TC, 26
	93580, 93581	
	93600-93612	TC, 26
	93613	
	93615-93619	TC, 26
	93620	26
	93621-93642	TC, 26
	93650-93652	
	93660	TC, 26
	93662	26
	93701	TC, 26
	93720-93722	
	93724	TC, 26
	93727	
	93731-93744	TC, 26
	93745	
	93760, 93762, 93770	TC, 26
	93784-93798	
	93799	TC, 26

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Appendix 1 (Continued)

Medicine Services (Continued)		
Service	CPT Procedure Code(s)	Allowable Modifier(s)
Pulmonary	94010	TC, 26
	94014-94016	
	94060-94621	TC, 26
	94640-94668	
	94680-94750	TC, 26
	94760	
	94770-94772, 94799	TC, 26
Allergy and Clinical Immunology	95004-95199	
Neurology and Neuromuscular Procedures	95805-95829	TC, 26
	95830-95857	
	95858-95962	TC, 26
	95965-95967	26
	95970-95991	
	95999	TC, 26
	96000-96004	
Central Nervous System Assessments/Tests	96100-96117	
Chemotherapy Administration	96400-96542, 96549	
Photodynamic Therapy	96567-96571	
Special Dermatological Procedures	96900, 96910-96999	
Physical Medicine and Rehabilitation	97001-97004, 97010-97542	
Osteopathic Manipulative Treatment	98925-98929	
Special Services Procedures and Reports	99000-99001	
	99070	
Other Services Procedures	99170, 99173, 99183-99199	

Category II Codes

Refer to the physician fee schedule for Category II Performance Measurement CPT codes. Category II codes consist of four numbers followed by the letter "F."

Category III Codes

Refer to the physician fee schedule for Category III Emerging Technology CPT codes. Category III codes consist of four numbers followed by the letter "T."

Appendix 1 (Continued)

Other Services		
Service	HCPCS Procedure Codes	Allowable Modifier(s)
Dental Procedures	D1203	
Procedures/Professional Services	G0000-G0201	
	G0202-G0230	TC, 26
	G0231-G0234	26
	G0237-G0239	
	G0242-G0243, G0251-G0256, G0261	TC, 26
	G0265-G0267, G0269	
	G0275-G0278	TC, 26
	G0279-G0280, G0281-G0289, G0290-G0291, G0297-G0300, G0307-G0309	
	G0336, G0341-G0343	TC, 26
	G0345-G0365	
Drugs Administered Other Than Oral Method	Wisconsin Medicaid reimburses the physician-administered drug codes ("J," "Q," and "S" codes) listed in the Physician Services Maximum Allowable Fee Schedule.	
Medical Services	M0064	
Q Codes (Temporary)	Q0035	TC, 26
	Q0081-Q0085, Q0111-Q0137, Q0163-Q0187, Q2001-Q2022, Q3001-Q3012, Q3025-Q3031, Q4001-Q4077, Q9941-Q9957	
Temporary National Codes (Non-Medicare)	S0017-S0088, S0091-S0093, S0114-S0132, S0155-S0191	
	S0820	TC, 26
	S1040, S2053-S2055, S2065, S2090, S2091, S2112-S2115, S2120, S2140, S2250, S2300, S2341, S2350-S2361, S2360-S2361, S2400-S2411, S3645-S3650	
	S3708, S8030-S8049, S8080-S8092	TC, 26
	S8225, S8262, S8950, S9022-S9024, S9034	

Appendix 2

Allowable Modifiers for Physician Evaluation and Management, Medicine, and Surgery Services

Wisconsin Medicaid accepts nationally recognized modifiers on claims and other forms, when applicable. The following table lists Medicaid-allowable modifiers for physician evaluation and management, medicine, and surgery services providers.

Note: Wisconsin Medicaid accepts all valid modifiers; however, not all modifiers are allowed by Wisconsin Medicaid's claims processing system.

Modifier	Description	Notes
26	Professional component	Refer to Appendix 1 of this section for procedure codes for which modifier "26" is allowable.
50	Bilateral procedure	Use of modifier "50" is allowed for those procedures for which the concept is considered appropriate according to standard coding protocols and Healthcare Procedure Coding System or <i>Current Procedural Terminology</i> definitions. Refer to the physician maximum allowable fee schedule for procedures in which this modifier is allowable.
54	Surgical care only	Use of modifier "54" is allowed only for cataract surgery procedure codes 66820-66821, 66830-66984 for preoperative care and surgery when post-operative care is performed by an optometrist. The surgeon is reimbursed at 90 percent of global maximum allowable fee for preoperative care and minor surgery or 80 percent for preoperative care and major surgery.
55	Postoperative management only	Use of modifier "55" is allowed only for cataract surgery procedure codes 66820-66821, 66830-66984 for postoperative care when performed by an optometrist.
80	Assistant surgeon	Use of modifier "80" is allowed for those surgery procedures recognized as accepted medical practice. Modifier "80" should be used regardless of the type of performing provider. Refer to the physician fee schedule for procedures for which this modifier is allowable.
AQ	Physician providing service in a HPSA	Providers receive enhanced reimbursement when services are performed in a Health Professional Shortage Area (HPSA). Refer to Appendix 25 of this section for a list of HPSA-eligible procedure codes.
TC	Technical component	Refer to Appendix 1 of this section for procedure codes for which modifier "TC" is allowable.
TH	Obstetrical treatment/ services, prenatal or postpartum	Providers are required to use modifier "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both modifiers "TH" and "AQ" when these prenatal services are HPSA eligible.
TJ	Program group, child and/or adolescent	Providers may use modifier "TJ" with procedure codes 99201-99215 and 99281-99285 only for recipients 18 years of age and younger. Providers should not bill the HPSA modifier with modifier "TJ."

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Appendix 3

Allowable Place of Service Codes for Physician Evaluation and Management, Medicine, and Surgery Services

Providers are required to indicate two-digit place of service (POS) codes on claims submitted to Wisconsin Medicaid. The following table lists Medicaid-allowable POS codes for physician evaluation and management, medicine, and surgery services.

POS code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance — Land
42	Ambulance — Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Disabled
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

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Appendix 4

CMS 1500 Claim Form Instructions for Physician Services

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

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the 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

Element 1 — Program Block/Claim Sort Indicator

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

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

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

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

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

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

Appendix 4 (Continued)

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

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

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
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 bill Wisconsin Medicaid for services that are included in the capitation payment.

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

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

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

Physicians are required to be Medicare enrolled to provide Medicare-covered services for dual eligibles. Dual eligibles are those recipients covered under both Medicare and Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage including Medicare Cost (“MCC”) or Medicare + Choice (“MPC”) for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

Appendix 4 (Continued)

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

Code	Description
M-5	<p>Provider is not Medicare certified. <i>(Not applicable to physicians)</i> This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. <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, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
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).

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

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

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

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

Appendix 4 (Continued)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (required for evaluation and management consultations and laboratory and radiology services only)

Enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician, excluding confirmatory consultations.

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

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

Family Planning Services

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are only contraceptive management related.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (required for selected surgeries and injection codes)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RP), HCF 11018. Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim. Refer to Appendix 15 of this section for procedures that require PA.

Element 24A — Date(s) of Service

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

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing only the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2004, indicate 12/01/04 or 12/01/2004 in the "From" field and indicate 08/15/22 in the "To" field.

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

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.

Appendix 4 (Continued)

- The charge for all services is identical. (Enter the total charge per detail line in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Appendix 3 of this section for allowable POS codes for physician services.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code. Refer to Appendix 1 of this section for Medicaid-allowable procedure codes for physician evaluation and management, medicine, and surgery services.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the “Modifier” column of Element 24D.

Note: Wisconsin Medicaid accepts all national modifiers, but only certain modifiers are allowed by Medicaid’s claims processing system. Refer to Appendix 2 of this section for Medicaid-allowable modifiers for physician services.

Element 24E — Diagnosis Code

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

Element 24F — \$ Charges

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

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan

Enter an “F” for each family planning procedure. If family planning does not apply, leave this element blank.

Element 24I — EMG

Enter an “E” for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

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

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

Appendix 4 (Continued)

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

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

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

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

Element 30 — Balance Due

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

Element 31 — Signature of Physician or Supplier

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

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

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

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

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

Appendix 5

Sample CMS 1500 Claim Form — Physician Medical Services (Three Evaluation and Management Visits with Pediatric Modifier)

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 (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <div style="text-align: center; font-size: 1.2em;">1234567890</div>																																																																																																																																																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <div style="font-size: 1.2em;">Recipient, Im A.</div>					3. PATIENT'S BIRTH DATE <div style="display: flex; justify-content: space-between;"> <div>MM DD YY</div> <div>SEX</div> </div> <div style="display: flex; justify-content: space-between;"> <div>MM DD YY</div> <div>M <input type="checkbox"/> F <input checked="" type="checkbox"/></div> </div>																																																																																																																																																										
5. PATIENT'S ADDRESS (No., Street) <div style="font-size: 1.2em;">609 Willow</div>					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 <div style="font-size: 1.2em;">Anytown</div>					STATE <div style="font-size: 1.2em;">WI</div>																																																																																																																																																										
ZIP CODE <div style="font-size: 1.2em;">55555</div>					TELEPHONE (Include Area Code) <div style="font-size: 1.2em;">(XXX) XXX-XXXX</div>																																																																																																																																																										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <div style="font-size: 1.2em;">OI - P</div>					10. IS PATIENT'S CONDITION RELATED TO:																																																																																																																																																										
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																										
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																										
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																										
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																																																																																																																																																										
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. <div style="display: flex; justify-content: space-between;"> <div>SIGNED _____</div> <div>DATE _____</div> </div>																																																																																																																																																															
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <div style="display: flex; justify-content: space-between;"> <div>SIGNED _____</div> <div>DATE _____</div> </div>																																																																																																																																																															
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																																																										
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																																																																										
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																																																										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) <div style="display: flex; justify-content: space-between;"> <div>1. <div style="font-size: 1.2em;">480.0</div></div> <div>3. _____</div> </div>					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																										
23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																															
<table border="1" style="width: 100%; border-collapse: collapse; font-size: 0.8em;"> <thead> <tr> <th colspan="4">A</th> <th>B</th> <th>C</th> <th colspan="2">D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> <th>K</th> </tr> <tr> <th colspan="4">DATE(S) OF SERVICE</th> <th>Place of Service</th> <th>Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>DIAGNOSIS CODE</th> <th>\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EPST Family Plan</th> <th>EMG</th> <th>COB</th> <th>RESERVED FOR LOCAL USE</th> </tr> <tr> <th>From</th> <th>To</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>CPT/HCPCS</th> <th>MODIFIER</th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>MM</td><td>DD</td><td>YY</td><td>DD</td><td>DD</td><td>11</td><td></td><td></td><td>99213</td><td>TJ</td><td>1</td><td>XXX XX</td><td>3.0</td><td></td><td></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										A				B	C	D		E	F	G	H	I	J	K	DATE(S) OF SERVICE				Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE	From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER						MM	DD	YY	DD	DD	11			99213	TJ	1	XXX XX	3.0																																																																																												
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28. TOTAL CHARGE \$ <div style="font-size: 1.2em;">XXX XX</div>					29. AMOUNT PAID \$ <div style="font-size: 1.2em;">XX XX</div>					30. BALANCE DUE \$ <div style="font-size: 1.2em;">XX XX</div>																																																																																																																																																					
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.) <div style="font-size: 1.2em;">J.M. Williams</div>					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 # <div style="font-size: 1.2em;">I.M. Physician 1 W. Williams Anytown, WI 55555 87654321</div>																																																																																																																																																					
SIGNED _____ DATE _____					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

Sample CMS 1500 Claim Form — Physician Obstetrical Services (Antepartum Care in a Health Professional Shortage Area)

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																																																
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> <div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) </div> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER </div> </div> </div> <div style="text-align: right;"> <div style="display: flex; align-items: center;"> PICA <input type="checkbox"/> </div> </div> </div> </div></div>																																																																																																																																																																																																																																																
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					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 MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F																																																																																																																																																																																																																																											
5. PATIENT'S ADDRESS (No., Street) 609 Willow					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. INSURED'S NAME (Last Name, First Name, Middle Initial) CITY STATE																																																																																																																																																																																																																																											
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 PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																											
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME					12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																																																																											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____																																																																																																																																																																																																																																																
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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 type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 659.80 3. _____ 2. _____ 4. _____																																																																																																																																																																																																																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPST Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th><th>MM</th><th>DD</th><th>YY</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th> </tr> </thead> <tbody> <tr> <td>MM</td><td>DD</td><td>YY</td><td></td><td></td><td></td><td>11</td><td></td><td></td><td>99204 TH AQ</td><td>1</td><td></td><td>XXX:XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>12345678</td> </tr> <tr> <td>MM</td><td>DD</td><td>YY</td><td>DD</td><td></td><td></td><td>11</td><td></td><td></td><td>99213 TH AQ</td><td>1</td><td></td><td>XXX:XX</td><td>2.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>12345678</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPST Family Plan		EMG		COB		RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																			MM	DD	YY				11			99204 TH AQ	1		XXX:XX	1.0									12345678	MM	DD	YY	DD			11			99213 TH AQ	1		XXX:XX	2.0									12345678																																																																																																																			
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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 \$ XXXX:XX																																																																																																																																																																																																																																						
29. AMOUNT PAID \$ XX:XX					30. BALANCE DUE \$ XX: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.) J.M. Williams MM/DD/YY																																																																																																																																																																																																																																						
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. Physician 1 W. Williams Anytown, WI 55555 87654321					PIN# _____ GRP# _____																																																																																																																																																																																																																																											

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Appendix 7

Sample CMS 1500 Claim Form — Physician Surgical Services (Bilateral Surgery)

HEALTH INSURANCE CLAIM FORM									
<div style="display: flex; justify-content: space-between;"> <div> <div> <input type="checkbox"/> PICA </div> <div> <div>1. MEDICARE</div> <div> <input type="checkbox"/> (Medicare #) </div> </div> <div> <div>MEDICAID</div> <div> <input checked="" type="checkbox"/> (Medicaid #) </div> </div> <div> <div>CHAMPUS</div> <div> <input type="checkbox"/> (Sponsor's SSN) </div> </div> <div> <div>CHAMPVA</div> <div> <input type="checkbox"/> (VA File #) </div> </div> <div> <div>GROUP HEALTH PLAN</div> <div> <input type="checkbox"/> (SSN or ID) </div> </div> <div> <div>FECA BLK LUNG</div> <div> <input type="checkbox"/> (SSN) </div> </div> <div> <div>OTHER</div> <div> <input type="checkbox"/> (ID) </div> </div> </div> <div> <div>1a. INSURED'S I.D. NUMBER</div> <div>(FOR PROGRAM IN ITEM 1)</div> <div>1234567890</div> </div> </div>									
<div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>Recipient, Im A.</div>				<div>3. PATIENT'S BIRTH DATE</div> <div>MM DD YY</div> <div>MM DD YY</div>		<div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div>		<div>5. PATIENT'S ADDRESS (No., Street)</div> <div>609 Willow</div>	
<div>6. PATIENT RELATIONSHIP TO INSURED</div> <div>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></div>				<div>7. INSURED'S ADDRESS (No., Street)</div>		<div>8. PATIENT STATUS</div> <div>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></div>		<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>OI - P</div>	
<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>a. EMPLOYMENT? (CURRENT OR PREVIOUS)</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div>				<div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div>		<div>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.</div>		<div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div>	
<div>14. DATE OF CURRENT:</div> <div>MM DD YY</div>				<div>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE</div> <div>MM DD YY</div>		<div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>FROM MM DD YY TO MM DD YY</div>		<div>17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</div>	
<div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>FROM MM DD YY TO MM DD YY</div>				<div>19. RESERVED FOR LOCAL USE</div>		<div>20. OUTSIDE LAB?</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div>		<div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)</div>	
<div>22. MEDICAID RESUBMISSION CODE</div> <div>996.79</div>				<div>23. PRIOR AUTHORIZATION NUMBER</div>		<div>24. A DATE(S) OF SERVICE</div> <div>From MM DD YY To MM DD YY</div>		<div>25. FEDERAL TAX I.D. NUMBER</div> <div>SSN EIN</div>	
<div>26. PATIENT'S ACCOUNT NO.</div> <div>1234JED</div>				<div>27. ACCEPT ASSIGNMENT?</div> <div>(For govt. claims, see back)</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div>		<div>28. TOTAL CHARGE</div> <div>\$ XXX XX</div>		<div>29. AMOUNT PAID</div> <div>\$ XXX XX</div>	
<div>30. BALANCE DUE</div> <div>\$ XX XX</div>				<div>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.)</div> <div>J.M. Authayed MM/DD/YY</div>		<div>32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)</div>		<div>33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #</div> <div>I.M. Physician</div> <div>1 W. Williams</div> <div>Anytown, WI 55555 87654321</div>	

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Appendix 8

Sample CMS 1500 Claim Form — End-Stage Renal Disease Services (Recipient Other Than Home Dialysis)

HEALTH INSURANCE CLAIM FORM										PICA <input type="checkbox"/>																																																																																																																																																																																		
<div style="display: flex; justify-content: space-between;"> <div> 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> </div> <div> 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <div style="border: 1px solid black; padding: 2px;">1234567890</div> </div> </div>																																																																																																																																																																																												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <div style="border: 1px solid black; padding: 2px;">Recipient, Im A.</div>				3. PATIENT'S BIRTH DATE <div style="display: flex; justify-content: space-between;"> <div>MM DD YY 02 10 96</div> <div>SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/></div> </div>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																						
5. PATIENT'S ADDRESS (No., Street) <div style="border: 1px solid black; padding: 2px;">609 Willow</div>				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 <div style="border: 1px solid black; padding: 2px;">Anytown</div>		STATE <div style="border: 1px solid black; padding: 2px;">WI</div>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		CITY		STATE																																																																																																																																																																																				
ZIP CODE <div style="border: 1px solid black; padding: 2px;">55555</div>		TELEPHONE (Include Area Code) <div style="border: 1px solid black; padding: 2px;">(XXX) XXX-XXXX</div>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE)																																																																																																																																																																																						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <div style="border: 1px solid black; padding: 2px;">OI - P</div>				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																						
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																						
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		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>																																																																																																																																																																																						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																												
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 _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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 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. <div style="border: 1px solid black; padding: 2px;">585</div> 2. _____			3. _____ 4. _____			23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																						
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO. <div style="border: 1px solid black; padding: 2px;">1234JED</div>			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ <div style="border: 1px solid black; padding: 2px;">XXX XX</div>			29. AMOUNT PAID \$ <div style="border: 1px solid black; padding: 2px;">XX XX</div>			30. BALANCE DUE \$ <div style="border: 1px solid black; padding: 2px;">XX XX</div>																																																																																																																																																																													
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.) <div style="border: 1px solid black; padding: 2px;">J.M. Authorized MM/DD/YY</div> 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 # <div style="border: 1px solid black; padding: 2px;"> I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# _____ GRP# _____ </div>																																																																																																																																																																																						

(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 9

Antepartum Care Claims Submission Guide

Providers should refer to the following table 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.

Indicate procedure codes 99204 with modifier “TH” and 99213 with modifier “TH” when submitting claims for one to three total antepartum care visits with the same provider or provider group. For example, if a total of two or three antepartum care visits is performed during a woman’s pregnancy, the provider should indicate procedure code 99204 with modifier “TH” and a quantity of “1.0” for the first date of service (DOS). For the second and third visits, the provider should indicate procedure code 99213 with modifier “TH” 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.

Similarly, for 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.”

Refer to the Surgery Services chapter of this section for more information on submitting claims for obstetric care using separate obstetric component procedure codes versus global obstetric procedure codes.

Antepartum Care Claims Submission Guide				
Total Visit(s)	Procedure Code and Description*		Modifier and Description	Quantity
1	99204 Office or other outpatient visit for the evaluation and management of a new patient ... Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.		TH (Obstetrical treatment/ services, prenatal or postpartum)	1.0
2	99204		TH	1.0
	99213 Office or other outpatient visit for the evaluation and management of an established patient ... Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.		TH	1.0
3	99204		TH	1.0
	99213		TH	2.0
4-6	59425	Antepartum care only; 4-6 visits		1.0
7+	59426	7 or more visits		1.0

*Refer to *Current Procedural Terminology* for a complete description of procedure codes 99204 and 99213.

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Appendix 10

Abortion Certification Statements (for photocopying)

ARCHIVAL USE ONLY
(A copy of the Abortion Certification Statements form is located on the following pages.)
Refer to the Online Handbook
for current policy

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Refer to the Online Handbook
for current policy

WISCONSIN MEDICAID ABORTION CERTIFICATION STATEMENTS

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.

Coverage Policy

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred **and** provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.

INSTRUCTIONS

When filing a claim for reimbursement of an abortion with Wisconsin Medicaid, physicians are required to attach a written certification statement attesting to one of the following circumstances. The following are sample certification statements that providers may use to certify the medical necessity of the abortion. 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.

SECTION I — LIFE OF THE WOMAN

I, _____, certify that
(Name — Provider)

on the basis of my best clinical judgment, abortion is directly and medically necessary to save the life of

_____, of
(Name — Recipient)

_____,
(Address — Recipient)

for the following reasons:

SIGNATURE — Physician

Date Signed

Continued

SECTION II — VICTIM OF SEXUAL ASSAULT OR INCEST

I, _____, certify that it is my belief that
(Name — Provider)
_____, of
(Name — Recipient)
_____, was the victim of sexual assault or incest.
(Address — Recipient)

SIGNATURE — Physician

Date Signed

SECTION III — GRAVE AND LONG-LASTING DAMAGE TO PHYSICAL HEALTH

I, _____, certify on the basis of
(Name — Provider)
my best clinical judgment that due to an existing medical condition, grave, long-lasting physical health damage to
_____, of
(Name — Recipient)
_____,
(Address — Recipient)

would result if the pregnancy were carried to term. The following medical condition necessitates the abortion (specify the medical condition / diagnosis):

SIGNATURE — Physician

Date Signed

Appendix 11

Sterilization Informed Consent Instructions and Sample

ARCHIVAL USE ONLY
(A copy of the Sterilization Informed Consent Form-Instructions and a sample of the form are located on the following pages.)
Refer to the Online Handbook
for current policy

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(This page was intentionally left blank.)
Refer to the Online Handbook
for current policy

WISCONSIN MEDICAID STERILIZATION INFORMED CONSENT FORM 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 Wisconsin 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 mandatory in order for Wisconsin Medicaid to reimburse providers for services. Any corrections to the form must be signed by the physician and/or recipient, as appropriate. The use of opaque correction fluids on the Sterilization Informed Consent form is prohibited. Instead, strike the incorrect information and initial the corrected information.

CONSENT TO STERILIZATION

The person who obtains the informed consent is required to provide orally all of the requirements for the informed consent as listed on the consent form, is required to offer to answer any questions, and is required to provide a copy of the consent form to the recipient to be sterilized for consideration during the waiting period. (The person obtaining consent need not be the physician performing the procedure.)

Suitable arrangements must be made to ensure that the required information is effectively communicated to the recipient to be sterilized if he or she is blind, deaf, or otherwise handicapped.

Element 1 — Doctor or Clinic (required)

The physician named in Element 1 is not required to match Elements 5 or 23. A recipient may receive information from one doctor/clinic and be sterilized by another. Corrections to this field must be initialed by the person obtaining consent or the physician.

Element 2 — Procedure (required)

The information given in Element 2 must be comparable, but not necessarily identical, to Elements 6, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Element 3 — Date of Birth (required)

Recipient's date of birth. The month, day, and year must be clearly indicated. Corrections to this field must be lined through and initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)

Element 4 — Name of Recipient (required)

The recipient's name must be legible. **Initials are acceptable for the first and/or middle name only.** The name may be typed. If this element does not match the signature in Element 7, check the Medicaid Eligibility Verification System (EVS) to verify that this is the same person. Consider the name in Element 4 to be the valid name. Corrections to this field must be initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)

Element 5 — Doctor (required)

The name of the doctor, affiliates, or associates is acceptable. The physician in Element 5 is not required to match Element 1 or 23. Corrections to this element must be initialed by the person obtaining consent or the physician. (A consent form is transferable and does **not** necessitate a new 30-day waiting period.)

Element 6 — Procedure (required)

The information given in Element 6 must be comparable, but not necessarily identical to, Elements 2, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Element 7 — Signature — Recipient (required)

The recipient's signature does not need to exactly match the name in Element 4; however, it is unacceptable for the recipient's signature to be completely different from the name in Element 4. Initials are acceptable for the first and/or middle name. An "X" is acceptable as a signature if a witness of the recipient's choice has signed the form. The individual obtaining consent may not act as a witness. There is no field on the form for a witness' signature; it should appear directly below the recipient signature element and be followed by the date of witness, which must match the recipient's signature date in Element 8. Corrections to Element 7 must be initialed by the recipient. (A correction does **not** require a new 30-day waiting period.)

Element 8 — Date (required)

The recipient must be at least 21 years old on this date. If the signature date is the recipient's 21st birthday, the claim is acceptable. At least 30 days but not more than 180 days, excluding the consent and surgery dates, must have passed between the date of the written informed consent and the date of sterilization, except in the case of premature delivery. Corrections to this field must be initialed by the recipient. (A correction does **not** require a new 30-day waiting period.)

Element 9 — Race and Ethnicity Designation (not required)

INTERPRETER'S STATEMENT

An interpreter must be provided to assist the recipient if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent.

Elements 10-12 — Language, Signature — Interpreter, Date Signed

If applicable, the date the interpreter signs can be on or prior to the recipient's signature date in Element 8.

STATEMENT OF PERSON OBTAINING CONSENT

Element 13 — Name of Individual (required)

The recipient's name does not need to exactly match the name in Element 4. Corrections to this field must be initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)

Element 14 — Procedure (required)

The information given in Element 14 must be comparable, but not necessarily identical, to Elements 2, 6, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Elements 15-18 — Signature — Person Obtaining Consent, Date Signed, Facility, Address (required)

The person obtaining the consent may be, but is not required to be, the physician performing the procedure. A facility and/or facility address must be indicated, but only one (of the provider's choice) is required. Additionally, the signature date (Element 16) can be prior to, on, or after the date the recipient signs (Element 8). Corrections to this field must be initialed by the person obtaining consent.

PHYSICIAN'S STATEMENT

Element 19 — Name of Individual to be Sterilized (required)

The recipient's name does not need to exactly match the name in Element 4. Corrections to this field must be initialed by the recipient. (This does **not** require a new 30-day waiting period.)

Element 20 — Date of sterilization (required)

The date must match the date of service (DOS) on the claim. Reimbursement is not allowed unless at least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of the sterilization. This means the DOS must be at least the 31st day after the recipient signature date and no later than the 181st day after that date. Neither the date of informed consent nor the date of surgery will be counted as part of the 30-day requirement. In cases of premature delivery, the consent form must have been signed at least 30 days prior to the expected date of delivery as identified in Element 22 and at least 72 hours must have passed before premature delivery. In cases of emergency abdominal surgery, at least 72 hours must have passed from the date the recipient gave informed consent to be sterilized. Element 22 must be completed in the case of premature delivery or emergency abdominal surgery. Corrections to this field must be initialed by the physician.

Note: Element 20 extends to the next line on the form.

Element 21 — Specify type of operation (required)

Must be comparable to Elements 2, 6, and 14 or state "same." If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)

Element 22 — Exception to 30-Day Requirement (required if less than 31 days have passed between date of signed consent and sterilization date)

The individual's expected date of delivery must be stated in the case of premature delivery. In the case of emergency abdominal surgery, the circumstances must be described. Corrections to this field must be initialed by the physician.

Element 23 — Signature — Physician and Date (required)

- Alterations to this field must be initialed by the physician.
- Initials may be used in the signature for the first and/or middle name only.
- A signature stamp or computer-generated signature is not acceptable.
- The physician's signature on the consent form does not need to exactly match the performing physician's name on the claim form. It is unacceptable for the physician's signature to be completely different from the name on the claim.
- Physician's signature date must be on or after the date the sterilization was performed.
- A nurse or other individual's signature is not acceptable.

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WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

■ STATEMENT OF PERSON OBTAINING CONSENT ■

I have asked for and received information about sterilization from _____
1
(doctor or clinic)

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an _____
2. The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally-funded programs.

I am at least 21 years of age and was born on _____
3
Month Day Year

I, _____
4 hereby consent of my own free will to be sterilized by _____
5
(doctor)

a method called _____
6. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare, or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

7 SIGNATURE — Recipient Date _____
8
Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or ☐ Black (not of Hispanic origin)
9 ☐ Alaska native ☐ Hispanic
☐ Asian or Pacific Islander ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____
10
language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 SIGNATURE — Interpreter _____
12 Date Signed

Before _____
13 signed the consent form,
name of individual

I explained to him/her the nature of the sterilization operation _____
14, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15 SIGNATURE — Person Obtaining Consent _____
16 Date Signed

17 Facility

18 Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____
19 on _____
20
Name of individual to be sterilized Date of sterilization

I explained to him/her the nature of the sterilization operation _____
21
operation

_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
22 ☐ Individual's expected date of delivery: _____
☐ Emergency abdominal surgery:
(describe circumstances): _____

23 SIGNATURE — Physician _____
Date Signed

Appendix 12

Sterilization Informed Consent (for photocopying)

ARCHIVAL USE ONLY
(A copy of the Sterilization Informed Consent form is located on the following page.)
Refer to the Online Handbook
for current policy

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an _____. The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally-funded programs.

I am at least 21 years of age and was born on _____ Month _____ Day _____ Year. I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare, or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature — Recipient _____ Date _____ Month _____ Day _____ Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or ☐ Black (not of Hispanic origin)
☐ Alaska native ☐ Hispanic
☐ Asian or Pacific Islander ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Signature — Interpreter _____ Date _____

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature — Person Obtaining Consent _____ Date _____

Facility _____

Address _____

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____

Name of individual to be sterilized _____ Date of sterilization _____
operation _____, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
☐ Individual's expected date of delivery: _____
☐ Emergency abdominal surgery:

(describe circumstances): _____

Signature — Physician _____ Date _____

Appendix 13

Acknowledgment of Receipt of Hysterectomy Information (for photocopying)

(A copy of the Acknowledgment of Receipt of Hysterectomy Information form
is located on the following pages.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

(This page was intentionally left blank.)

ARCHIVAL USE ONLY

Refer to the Online Handbook
for current policy

WISCONSIN MEDICAID ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

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.

INSTRUCTIONS

The Acknowledgement of Receipt of Hysterectomy Information form is to be completed by a physician before performing the surgery and attached to the CMS 1500 claim form. 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.

Medicaid reimbursement for a hysterectomy requires the completion of this form or similar form with the same information. This form is not to be used for purposes of consent of sterilization. A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form, HCF 1164.

Name — Recipient

Enter the recipient's last name, first name, and middle initial. Use the Medicaid 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. The name in this element must match the name on the claim.

Recipient Medicaid ID No.

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

Address — Recipient

Enter the recipient's address. Use the EVS to obtain the recipient's address.

Name — Physician

Enter the performing provider's name.

Physician's Medicaid Provider No.

Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

Name — Recipient

Enter the recipient's name. The name in this element must match the recipient's name entered at the top of the form.

Signatures — Recipient, Representative, and Interpreter

Recipient — The recipient must sign and date this element. (Signing this form does not require the recipient to undergo the hysterectomy surgery.)

Representative — The representative must sign and date this element if a representative was required for the recipient.

Interpreter — An interpreter must sign and date this element if the recipient does not understand the language used on the form and if an interpreter was used to translate this information.

Date Signed

Enter the date the recipient signs the Acknowledgement of Receipt of Hysterectomy Information form in this element. This date must be on or before the date of service on the claim.

Continued

**WISCONSIN MEDICAID
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION**

Name — Recipient	Recipient Medicaid Identification Number
Address — Recipient	
Name — Physician	Wisconsin Medicaid Provider Number

It has been explained _____ (me) that the hysterectomy to be
(Name — Recipient)
performed on her (me) will render her (me) permanently incapable of reproducing.

SIGNATURES — Recipient, Representative, and Interpreter	
Recipient	Date Signed
Representative	Date Signed
Interpreter	Date Signed

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 14

Breast Pump Order (for photocopying)

ARCHIVAL USE ONLY
(A copy of the Breast Pump Order form is located on the following page.)
Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
BREAST PUMP ORDER**

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.

INSTRUCTIONS

The form is to be completed by the physician, given to the provider of the breast pump, and kept in the recipient's medical record as required under HFS 106.02(9), Wis. Admin. Code. 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.

		1. Date of Order
2. Name — Recipient (Mother)		3. Address — Recipient
4. Date of Birth — Infant	5. Recipient Medicaid Identification Number	
6. Clinical Guidelines <p>All of the following must apply as a condition for Medicaid coverage. By checking the boxes, the physician verifies that all conditions are met.</p> <p><input type="checkbox"/> Physician ordered or recommended breast milk for infant.</p> <p><input type="checkbox"/> Potential exists for adequate milk production.</p> <p><input type="checkbox"/> Recipient plans to breast-feed long term.</p> <p><input type="checkbox"/> Recipient is capable of being trained to use the breast pump.</p> <p><input type="checkbox"/> Current or expected physical separation of mother and infant (e.g., illness, hospitalization, work) would make breast-feeding difficult, or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.</p>		
7. Type of Pump <p>The physician orders or recommends the following breast pump for use by the recipient:</p> <p><input type="checkbox"/> Breast pump, manual, any type.</p> <p><input type="checkbox"/> Breast pump, electric (AC and / or DC), any type.</p> <p><input type="checkbox"/> Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction / release cycles, vacuum regulator, supplies transformer, electric (AC and / or DC).</p>		
8. Name — Physician (Type or Print)		9. Address — Physician
10. SIGNATURE — Physician		11. Date Signed

Appendix 15

Physician Services Requiring Prior Authorization

General Instructions

The list of procedures requiring prior authorization (PA) is subject to change and is periodically updated by Wisconsin Medicaid. General services requiring PA include the following:

- All covered physician services if provided out-of-state under nonemergency circumstances by a provider who does not have border-status certification with Wisconsin Medicaid.
- Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

Specific physician services that require PA are listed in this appendix. Contact a Medicaid-certified pharmacist or Provider Services at (800) 947-9627 or (608) 221-9883 for information regarding possible PA or diagnosis restrictions for a particular drug.

Special Circumstances

Audiological Testing for Hearing Instruments

A Prior Authorization/Physician Otological Report (PA/POR), HCF 11019, is required for audiological testing for specifications of a hearing instrument. A photocopy of the approved hearing instrument PA request form is sent to the recipient who presents it to the Medicaid-certified audiologist or hearing instrument specialist of his or her choice.

Dermabrasion

Prior authorization requests for dermabrasion (procedure codes 15780-15783) will not be approved if the purpose is tattoo removal.

Bariatric Surgery

Bariatric surgery for treatment of morbid obesity is allowed only in limited circumstances. Refer to the Surgery Services chapter of this section for more information.

Infertility and Impotence Services

Treatment of infertility and impotence are noncovered services under Wisconsin Medicaid. Drugs whose primary use is treatment of infertility or impotence may be approved through PA only when used for treatment of conditions other than infertility or impotence.

Organ Transplants

The hospital, rather than the physician, is responsible for obtaining PA for these services. Physicians should make sure all necessary approvals have been obtained by the hospital before proceeding with a transplant operation. Wisconsin Medicaid does not require PA for collection of the donor organ.

Plagiocephaly — Occipital Plagiocephaly Cranial Banding (Cranial Remodeling Orthosis [Helmet])

Prior authorization requests for infant head molding bands (procedure code S1040) to correct skull deformities in infants require photographic and medical record documentation. The orthosis is only allowed for infants under 18 months of age at the time of initiation of service.

Appendix 15 (Continued)

Penile Prosthesis

Insertion or replacement of semirigid penile prosthesis (procedure codes 54400, 54416, and 54417) may be approved through PA only when the prosthesis is employed for purposes other than treatment of impotence (e.g., to support a penile catheter). Replacement of an inflatable penile prosthesis is not a covered service under Wisconsin Medicaid.

Vaginal Construction

Vaginal construction (procedure codes 57291 and 57292) may be approved through PA only when performed on a female (e.g., correction of a congenital defect). It will not be approved as part of a transsexual surgery.

Weight Management Services

All medical services (beyond five evaluation and management office visits per calendar year) aimed specifically at weight management and procedures to reverse such services require PA.

Procedure Codes Requiring Prior Authorization

The following procedure codes require PA from Wisconsin Medicaid. The list of procedures requiring PA is subject to change and is periodically updated by Wisconsin Medicaid.

Category	Proc. Code	Description
Drugs Administered Other than Oral	J0256	Injection, alpha 1 — proteinase inhibitor — human, 10 mg
	J0270	Injection, alprostadil, per 1.25 mcg
	J0725	Injection, chorionic gonadotropin, per 1,000 USP units
	J2760	Injection, phentolamine mesylate (Regitine), up to 5 mg
	J3490*	Unclassified drugs
Q Codes (Temporary)	Q2014	Injection, sermorelin acetate, 0.5 mg
Temporary National Codes (Non-Medicare)	S1040	Cranial remolding orthosis, rigid, with soft interface, material, custom fabricated, includes fitting and adjustment(s)
	S2053	Transplantation of small intestine and liver allografts
	S2054	Transplantation of multivisceral organs
	S2055	Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor
Integumentary System	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
	11951	1.1 to 5.0 cc
	11952	5.1 to 10.0 cc
	11954	over 10.0 cc
	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	11970	Replacement of tissue expander with permanent prosthesis
	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
	15781	segmental, face

*Requires PA *only* when drug may also be used as a fertility drug.

Appendix 15 (Continued)

Category	Proc. Code	Description
Integumentary System (Continued)	15782	regional, other than face
	15783	superficial, any site (eg, tattoo removal)
	15820	Blepharoplasty, lower eyelid;
	15821	with extensive herniated fat pad
	15822	Blepharoplasty, upper eyelid;
	15823	with excessive skin weighting down lid
	15824	Rhytidectomy; forehead
	15825	neck with platysmal tightening (platysmal flap, P-flap)
	15826	glabellar frown lines
	15828	cheek, chin, and neck
	15829	superficial musculoaponeurotic system (SMAS) flap
	15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)
	15832	thigh
	15833	leg
	15834	hip
	15835	buttock
	15836	arm
	15837	forearm or hand
	15838	submental fat pad
	15839	other area
	19140	Mastectomy for gynecomastia
	19316**	Mastopexy
	19318**	Reduction mammoplasty
	19324**	Mammoplasty, augmentation; without prosthetic implant
	19325**	with prosthetic implant
	19340**	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19342**	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19350**	Nipple/areola reconstruction
	19357**	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
	19361**	Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant
	19364**	Breast reconstruction with free flap
	19366**	Breast reconstruction with other technique
	19367**	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
	19368**	with microvascular anastomosis (supercharging)
	19369**	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
	19380**	Revision of reconstructed breast
	19396**	Preparation of moulage for custom breast implant

**Does not require PA if diagnosis is breast cancer (*International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes 174.0-174.9, 175.0-175.9, 233.0, 238.3, 239.3).

Appendix 15 (Continued)

Category	Proc. Code	Description
Musculoskeletal System	21010	Arthrotomy, temporomandibular joint
	21050	Condylectomy, temporomandibular joint (separate procedure)
	21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
	21070	Coronoidectomy (separate procedure)
	21079	Impression and custom preparation; interim obturator prosthesis
	21080	definitive obturator prosthesis
	21081	mandibular resection prosthesis
	21082	palatal augmentation prosthesis
	21083	palatal lift prosthesis
	21084	speech aid prosthesis
	21085	oral surgical splint
	21086	auricular prosthesis
	21087	nasal prosthesis
	21088	facial prosthesis
	21089	Unlisted maxillofacial prosthetic procedure
	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	sliding osteotomy, single piece
	21122	sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
	21123	sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
	21125	Augmentation, mandibular body or angle; prosthetic material
	21127	with bone graft, onlay or interpositional (includes obtaining autograft)
	21137	Reduction forehead; contouring only
	21138	contouring and application of prosthetic material or bone graft (includes obtaining autograft)
	21139	contouring and setback of anterior frontal sinus wall
	21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
	21142	two pieces, segment movement in any direction, without bone graft
	21143	three or more pieces, segment movement in any direction, without bone graft
	21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
	21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
	21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
	21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
	21151	any direction, requiring bone grafts (includes obtaining autografts)

Appendix 15 (Continued)

Category	Proc. Code	Description
Musculoskeletal System (Continued)	21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autographs); without LeFort I
	21155	with LeFort I
	21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autographs); without LeFort I
	21160	with LeFort I
	21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autographs)
	21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autographs)
	21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
	21180	with autograft (includes obtaining grafts)
	21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
	21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
	21183	total area of bone grafting greater than 40 sq cm but less than 80 sq cm
	21184	total area of bone grafting greater than 80 sq cm
	21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autographs)
	21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
	21194	with bone graft (includes obtaining graft)
	21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
	21196	with internal rigid fixation
	21198	Osteotomy, mandible, segmental
	21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
	21209	reduction
	21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
	21215	mandible (includes obtaining graft)
	21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
	21235	ear cartilage, autogenous, to nose or ear (includes obtaining graft)
	21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
	21242	Arthroplasty, temporomandibular joint, with allograft

Appendix 15 (Continued)

Category	Proc. Code	Description
Musculoskeletal System (Continued)	21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	complete
	21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
	21249	complete
	21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
	21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
	21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
	21261	combined intra- and extracranial approach
	21263	with forehead advancement
	21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
	21268	combined intra- and extracranial approach
	21270	Malar augmentation, prosthetic material
	21275	Secondary revision of orbitocraniofacial reconstruction
	21280	Medial canthopexy (separate procedure)
	21282	Lateral canthopexy
	21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
	21296	intraoral approach
	21299	Unlisted craniofacial and maxillofacial procedure
	21740	Reconstructive repair of pectus excavatum or carinatum; open
Respiratory System	30120	Excision or surgical planing of skin of nose for rhinophyma
	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	intermediate revision (bony work with osteotomies)
	30450	major revision (nasal tip work and osteotomies)
	32851	Lung transplant, single; without cardiopulmonary bypass [transplant center obtains PA, not physician]
	32852	with cardiopulmonary bypass [transplant center obtains PA, not physician]
	32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass [transplant center obtains PA, not physician]
	32854	with cardiopulmonary bypass [transplant center obtains PA, not physician]

Appendix 15 (Continued)

Category	Proc. Code	Description
Cardiovascular System	33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy [transplant center obtains PA, not physician]
	33945	Heart transplant, with or without recipient cardiectomy [transplant center obtains PA, not physician]
	37650	Ligation of femoral vein
Hemic and Lymphatic System	38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic [transplant center obtains PA, not physician]
	38241	autologous [transplant center obtains PA, not physician]
Digestive System	42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
	42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)
	43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux limb 150 cm or less)
	43645	with gastric bypass and small intestine reconstruction to limit absorption
	43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
	43843	other than vertical-banded gastroplasty
	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy
	43847	with small intestine reconstruction to limit absorption
	43848	Revision of gastric restrictive procedure for morbid obesity (separate procedure)
	44135	Intestinal allotransplantation; from cadaver donor
	44136	from living donor
	44137	Removal of transplanted intestinal allograft, complete
	47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age [transplant center obtains PA, not physician]
	47136	heterotopic, partial or whole, from cadaver or living donor, any age [transplant center obtains PA, not physician]
	47399	Unlisted procedure, liver (PA required only for liver-small intestine transplant) [transplant center obtains PA, not physician]
	48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells [transplant center obtains PA, not physician]
	48554	Transplantation of pancreatic allograft [transplant center obtains PA, not physician]
Male Genital System	54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
	54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
	54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue

Appendix 15 (Continued)

Category	Proc. Code	Description
Female Genital System	57291	Construction of artificial vagina; without graft
	57292	with graft
	58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
	58410	with presacral sympathectomy
Nervous System	61490	Craniotomy for lobotomy, including cingulotomy
	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
	64573	Incision for implantation of neurostimulator electrodes; cranial nerve
Eye and Ocular Adnexa	67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material
	67902	frontalis muscle technique with fascial sling (includes obtaining fascia)
	67903	(tarso) levator resection or advancement, internal approach
	67904	(tarso) levator resection or advancement, external approach
	67906	superior rectus technique with fascial sling (includes obtaining fascia)
	67908	conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
	67909	Reduction of overcorrection of ptosis
Auditory System	69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
	69715	with mastoidectomy
	69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
	69718	with mastoidectomy
	69930	Cochlear device implantation, with or without mastoidectomy
Special Otorhinolaryngologic Services	92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming

Appendix 16

Prior Authorization Request Form (PA/RF) Completion Instructions for Physician 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, including the Prior Authorization/Physician Attachment (PA/PA), HCF 11016, or the Prior Authorization/“J” Code Attachment (PA/JCA), HCF 11034, to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to:

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

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

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

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type “117” (physician services, including family planning clinics, rural health clinics, and federally qualified health centers). The processing type is a three-digit code used to identify a category of service requested.

Element 4 — Billing Provider’s Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

Appendix 16 (Continued)

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the 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, 1996, would be 09/08/96).

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

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

Element 16 — Procedure Code

Enter the appropriate procedure code for each service/procedure/item requested. Refer to Appendix 15 of this section for a list of procedures that require prior authorization.

Appendix 16 (Continued)

Element 17 — Modifiers

Enter up to four modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid. Refer to Appendix 1 of this section for a list of allowable modifiers.

Element 18 — POS

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 3 of this section for a list of allowable POS codes.

Element 19 — Description of Service

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

Element 20 — QR

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

Element 21 — Charge

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

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to 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.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

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

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

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Appendix 17

Sample Prior Authorization Request Form (PA/RF)

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

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

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

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 87654321		3. Processing Type 117	
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) 1234 Street St. Anytown, WI 55555			
8. Name — Recipient (Last, First, Middle Initial) Recipient, Ima A.				9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F					
SECTION III — DIAGNOSIS / TREATMENT INFORMATION									
10. Diagnosis — Primary Code and Description 611.9 Unspecified breast disorder						11. Start Date — SOI		12. First Date of Treatment — SOI	
13. Diagnosis — Secondary Code and Description 724.5 Backache, unspecified						14. Requested Start Date 11/01/03			
15. Performing Provider Number 98765432		16. Procedure Code 19318		17. Modifiers 1 2 3 4 50		18. POS 21		19. Description of Service Reduction mammoplasty	
								20. QR 1	
								21. Charge 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.								22. Total Charges XXX.XX	
23. SIGNATURE — Requesting Provider <div style="text-align: center; margin-top: 10px;"> </div>								24. Date Signed MM/DD/YY	
FOR MEDICAID USE <div style="float: right; text-align: right;"> Procedure(s) Authorized: _____ Quantity Authorized: _____ </div>									
<input type="checkbox"/> Approved <div style="margin-left: 100px;"> _____ 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 18

Prior Authorization / Physician Attachment (PA/PA) Completion Instructions

(A copy of the Prior Authorization Physician/Attachment (PA/PA) Completion Instructions is located on the following page.)

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for current policy

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Refer to the Online Handbook
for current policy

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

Complete the Prior Authorization/Physician Attachment (PA/PA), HCF 11016, including the Prior Authorization Request Form (PA/RF), HCF 11018, and submit it by fax to (608) 221-8616. Providers also have the option of submitting PA requests by mail to the following address:

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

Providers with questions about completing PA requests should call Provider Services at (800) 947-9627 or (608) 221-9883.

To obtain copies of PA forms, providers have the following options:

- Download and print a copy of the form from the Medicaid Web site.
- Photocopy the attachment.
- Order copies by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

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

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, first name, and middle initial. Use the Medicaid 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 — Date of Birth

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

Element 3 — Recipient Medicaid Identification Number

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

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider

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

Element 5 — Performing Provider's Medicaid Provider Number

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

Element 6 — Telephone Number — Performing Provider

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

Element 7 — Name — Ordering / Prescribing Physician

Enter the name of the referring/prescribing physician in this element.

SECTION III — SERVICE INFORMATION

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete Elements A through C.
2. Sign and date the PA/PA (Element D).

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

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Appendix 19

Sample Prior Authorization / Physician Attachment (PA/PA)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11016 (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(2), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION / PHYSICIAN ATTACHMENT (PA/PA)

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Physician Services Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Physician Attachment (PA/PA) to the Prior Authorization Request Form (PA/RF), HCF 11018, 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

Refer to the Online Handbook
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

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

Recipient, Ima A.

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

02/03/1955

3. Recipient Medicaid Identification Number

1234567890

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

I.M. Performing

5. Performing Provider's Medicaid Provider Number

12345678

6. Telephone Number — Performing Provider

(XXX) XXX-XXXX

7. Name — Ordering / Prescribing Physician

I.M. Referring/Prescribing

Continued

SECTION III — SERVICE INFORMATION

A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

Bilateral mammary hyperplasia. Patient is 62" tall and weighs 250 lbs. (2.10 m²). Previous treatments consisting of ... have been tried for 3 months and have failed to reduce or alleviate symptoms.

B. Describe medical history pertinent to service or procedure requested.

Has constant infection and weeping under the mammary fold. 2-3 years of neck and back pain. Bilateral shoulder grooving; unable to perform routine gym exercises, constant rash beneath breasts with seaming and superficial ulceration.

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C. Supply justification for service or procedure requested.

The breast structures are quite heavy and pendulous. In excess of 750 grams will be removed from each breast (per Schneer*).

*establish a medical rationale for the procedure with >750 grams/breast with this BSA g 2.10m².

D. SIGNATURE — Physician

I.M. Provider

Date Signed

MM/DD/YYYY

Appendix 20

Prior Authorization / Physician Attachment (PA/PA) (for photocopying)

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

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Refer to the Online Handbook
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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN ATTACHMENT (PA/PA)**

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

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

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

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Physician Services Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Physician Attachment (PA/PA) to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

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

SECTION I — RECIPIENT INFORMATION

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

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

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

5. Performing Provider's Medicaid Provider Number

6. Telephone Number — Performing Provider

7. Name — Ordering / Prescribing Physician

Continued

SECTION III — SERVICE INFORMATION

A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

B. Describe medical history pertinent to service or procedure requested.

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C. Supply justification for service or procedure requested.

D. SIGNATURE — Physician	Date Signed
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Appendix 21

Prior Authorization / "J" Code Attachment (PA/JCA) Completion Instructions

(A copy of the Prior Authorization/"J" Code Attachment [PA/JCA] Completion Instructions is located on the following pages.)

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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / "J" CODE ATTACHMENT (PA/JCA)
COMPLETION INSTRUCTIONS**

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

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

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

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

Physicians use this form to request PA for injectable drug ("J") codes. Attach the completed Prior Authorization/"J" Code Attachment (PA/JCA), HCF 11034, to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid 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 — Date of Birth — Recipient

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

Element 3 — Recipient Medicaid Identification Number

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

SECTION II — DRUG ORDER INFORMATION

Complete all of Section II.

SECTION III — CLINICAL INFORMATION

Element 14 — Diagnosis

List the recipient's condition that the prescribed drug is intended to treat. Include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and the expected length of need.

Element 15 — Changes to Previous Prior Authorization

If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to-date.

Element 16 — Use (check one)

Any of the compendium standards may be used. If an intended use is not in the drug package insert, providers may want to check the United States Pharmacopeia-Drug Information (USP-DI) for the most inclusive reference for diagnosis.

Drugs not listed in compendium standards may be covered by Wisconsin Medicaid; therefore, the PA/JCA must be submitted for processing and denied before the recipient is told a particular drug is not covered by Wisconsin Medicaid.

Element 17 — Dose (check one)

Any of the compendium standards may be used. If a prescribed dosage is not in the drug package insert, providers may want to check the USP-DI (the most inclusive reference for diagnosis).

Drugs not listed in compendium standards may be covered by Wisconsin Medicaid; therefore, the PA/JCA must be submitted for processing and denied before the recipient is told a particular drug is not covered by Wisconsin Medicaid.

Elements 18 and 19 — Signature — Prescriber and Date Signed

The prescriber is required to review the information, verifying that the information is accurate to the best of his or her knowledge, and sign and date the PA/JCA.

Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Indicate a fax or telephone number if selecting either of these options.

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Appendix 22

Prior Authorization / "J" Code Attachment (for photocopying)

(A copy of the Prior Authorization/"J" Code Attachment [PA/JCA] is located on the following pages.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / "J" CODE ATTACHMENT (PA/JCA)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail 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/"J" Code Attachment (PA/JCA) Completion Instructions, HCF 11034A.

SECTION I — RECIPIENT INFORMATION

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

2. Date of Birth — Recipient

3. Recipient Medicaid Identification Number

SECTION II — DRUG ORDER INFORMATION

4. Drug Name

5. Strength

6. National Drug Code

7. HCPCS "J" Code

8. Quantity Ordered

9. Date Order Issued

10. Daily Dose

11. Name — Prescriber

12. Drug Enforcement Agency Number

13. "Brand Medically Necessary"

☐

Yes

☐

No

SECTION III — CLINICAL INFORMATION

14. Diagnosis

15. Changes to Previous Prior Authorization (If Applicable)

Continued

SECTION III — CLINICAL INFORMATION (Continued)

16. Use (Check One)

- ☐ Compendium standards, such as the USP-DI or drug package insert, list the intended use identified in Element 14 as an accepted or a [bracketed] indication.
- ☐ The intended use identified in Element 14 is *not* listed in compendium standards. Peer reviewed clinical literature is attached.

17. Dose (Check One)

- ☐ The daily dose and duration are within compendium standards of general prescribing or dosing limits for the indicated use.
- ☐ The daily dose and duration are not within compendium standards of general prescribing or dosing limits for the intended use. Attach peer-reviewed literature that indicates this dose is appropriate or document the medical necessity of this dosing difference.

18. **SIGNATURE** — Prescriber

19. Date Signed

Notify me of approval / denial by one of the following:

- ☐ Fax — Fax Number — _____
- ☐ Telephone — Telephone Number — _____
- ☐ No special notice needed.

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Appendix 23

Prior Authorization / Physician Otological Report (PA/POR) Completion Instructions

(A copy of the Prior Authorization/Physician Otological Report [PA/POR] Completion Instructions is located on the following pages.)

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Refer to the Online Handbook
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**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR)
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 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 Prior Authorization/Physician Otolological Report (PA/POR), HCF 11019, is required by Wisconsin Medicaid when a hearing instrument specialist requires PA for a hearing instrument. Audiologists may use the PA/POR in place of a physician prescription, which is to be kept in the recipient's medical record. Upon completion, the provider should give one copy to the recipient to take to the testing center and retain a second copy in the recipient's medical record.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Physician

Enter the name of the requesting physician.

Element 2 — Physician's UPIN, Medicaid Provider Number, or License Number

Enter the six-digit Medicare Universal Provider Identification Number, eight-digit Medicaid provider number, or license number of the physician.

Element 3 — Address — Physician

Enter the address (street, city, state, zip code) of the requesting physician.

Element 4 — Telephone Number — Physician

Enter the telephone number, including area code, of the requesting physician.

SECTION II — RECIPIENT INFORMATION

Element 5 — Name — Recipient

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

Element 6 — Date of Birth — Recipient

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

Element 7 — Address — Recipient

Enter the complete address (street, city, state, and zip code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 8 — Recipient Medicaid Identification Number

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

Element 9 — Sex — Recipient

Enter an "X" in the appropriate box.

SECTION III — DOCUMENTATION

Element 10 — Medical History of Hearing Loss

Enter the recipient's medical history of hearing loss (if any).

Element 11 — Pertinent Otological Findings

Enter an "X" in the appropriate box(es) and describe all problems.

Element 12 — Describe Additional Findings

Describe any additional findings not covered in Element 11.

Element 13 — Clinical Diagnosis of Hearing Status

Enter the diagnosis of the recipient's hearing status.

Element 14 — Medical, Cognitive, or Developmental Problems

Describe any medical, cognitive, or developmental problems of the recipient.

Element 15 — Physician's Recommendations

Check the appropriate box(es) to indicate the physician's recommendations.

Signature — Physician and Date Signed

The requesting physician must sign the form and enter the date the request is made.

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Appendix 24

Prior Authorization / Physician Otological Report (PA/POR) (for photocopying)

(A copy of the Physician Otological Report (PA/POR) (for photocopying) is located on the following page.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR)

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/Physician Otolological Report (PA/POR) Completion Instructions (HCF 11019A).

SECTION I — PROVIDER INFORMATION

1. Name — Physician	2. Physician's UPIN, Medicaid Provider Number, or License Number
3. Address — Physician (Street, City, State, Zip Code)	4. Telephone Number — Physician

SECTION II — RECIPIENT INFORMATION

5. Name — Recipient (Last, First, Middle Initial)	6. Date of Birth — Recipient
7. Address — Recipient (Street, City, State, Zip Code)	
8. Recipient Medicaid Identification Number	9. Sex — Recipient <input type="checkbox"/> Male <input type="checkbox"/> Female

SECTION III — DOCUMENTATION

10. Medical History of Hearing Loss																						
<div style="text-align: center; font-weight: bold; margin-bottom: 10px;">ARCHIVAL USE ONLY Refer to the Online Handbook for current policy</div> <table style="width: 100%;"><thead><tr><th style="width: 15%;"></th><th style="width: 15%; text-align: center;">Normal (check below)</th><th style="width: 15%; text-align: center;">Problems (describe)</th></tr></thead><tbody><tr><td>Right: Canal</td><td style="text-align: center;"><input type="checkbox"/></td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Ear Drum</td><td style="text-align: center;"><input type="checkbox"/></td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Middle Ear</td><td style="text-align: center;"><input type="checkbox"/></td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Left: Canal</td><td style="text-align: center;"><input type="checkbox"/></td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Ear Drum</td><td style="text-align: center;"><input type="checkbox"/></td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Middle Ear</td><td style="text-align: center;"><input type="checkbox"/></td><td style="border-bottom: 1px solid black;"></td></tr></tbody></table>		Normal (check below)	Problems (describe)	Right: Canal	<input type="checkbox"/>		Ear Drum	<input type="checkbox"/>		Middle Ear	<input type="checkbox"/>		Left: Canal	<input type="checkbox"/>		Ear Drum	<input type="checkbox"/>		Middle Ear	<input type="checkbox"/>		12. Describe Additional Findings (e.g., results of special studies, such as caloric and postural tests)
	Normal (check below)	Problems (describe)																				
Right: Canal	<input type="checkbox"/>																					
Ear Drum	<input type="checkbox"/>																					
Middle Ear	<input type="checkbox"/>																					
Left: Canal	<input type="checkbox"/>																					
Ear Drum	<input type="checkbox"/>																					
Middle Ear	<input type="checkbox"/>																					
13. Clinical Diagnosis of Hearing Status																						
14. Medical, Cognitive, or Developmental Problems																						
15. Physician's Recommendations (check all applicable) <input type="checkbox"/> I have medically evaluated this patient and refer him / her for a hearing instrument evaluation as follows: <div style="margin-left: 20px;"><input type="checkbox"/> One or more of the situations listed below applies to this patient. Therefore, as required by Medicaid regulations, I refer this patient to an audiologist for a hearing instrument evaluation / diagnosis: <div style="margin-left: 20px;"><input type="checkbox"/> The patient is 21 years of age or under. <input type="checkbox"/> The patient is behaviorally or cognitively impaired. <input type="checkbox"/> The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.</div></div> <div style="margin-left: 20px;"><input type="checkbox"/> None of the above situations applies to this patient. Either an audiologist or a hearing instrument specialist may provide the hearing instrument evaluation.</div> <div style="margin-left: 20px;"><input type="checkbox"/> A home hearing test is required.</div>																						

SIGNATURE — Physician

Date Signed

Appendix 25

Health Professional Shortage Area-Eligible Procedure Codes and ZIP Codes

Wisconsin Medicaid provides enhanced reimbursement for selected procedures for primary care providers and emergency medicine providers who either provide care within areas designated by the federal Health Resources and Services Administration (HRSA) as a Health Professional Shortage Area (HPSA) or who provide care for recipients who reside in these areas. Providers may submit claims with HPSA modifier “AQ” (Physician providing a service in a HPSA) to receive a 50 percent bonus incentive. While the modifier is defined for physicians only, any Medicaid HPSA-eligible provider may use them with the following procedure codes.

Health Professional Shortage Area-Eligible Procedure Codes	
Category	Procedure Code(s)
Evaluation and Management Services*	
New Patient	99201, 99202, 99203, 99204, 99205
Established Patient	99211, 99212, 99213, 99214, 99215
Emergency Department	99281, 99282, 99283, 99284, 99285
Newborn Care	99431, 99432, 99433, 99435, 99436, 99440
Preventive Medicine	94772, 96110, 99386, 99387, 99396, 99397
Obstetric Care	59020, 59025, 59050, 59300, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 76801, 76802, 76805, 76810, 76811, 76815, 76816, 76818, 76819, 76825, 76826, 76827, 76828 99204 + modifier "TH" (for initial antepartum care visit)** 99213 + modifier "TH" (for two to three antepartum care visits, after initial visit)**
Vaccines	90701, 90702, 90704, 90705, 90706, 90707, 90708, 90712, 90713, 90718, 90744

*Providers should not submit claims with HPSA modifier “AQ” and modifier “TJ” (Program group, child and/or adolescent) for procedure codes 99201-99215 and 99281-99285. Providers should use only a HPSA modifier, when applicable. Wisconsin Medicaid will determine the recipient’s age and determine the proper HPSA reimbursement for these procedure codes.

**Providers are required to use modifier “TH” (Obstetrical treatment/services, prenatal or postpartum) with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both the “TH” modifier and HPSA modifier “AQ” when these prenatal services are HPSA eligible for appropriate reimbursement.

Continued

Appendix 25 (Continued)

Health Professional Shortage Areas

The county is listed for informational purposes only. Not all ZIP codes in a county may be included in the HPSA.

HPSA Name	County	ZIP Codes
Adams County	Adams	Entire county: 53910, 53920, 53927, 53934, 53936, 53952, 53964, 53965, 54457, 54613, 54921, 54930, 54943, 54966
Augusta/Osseo	Eau Claire	54722, 54741, 54758, 54770
	Jackson	54635, 54741, 54758
	Trempealeau	54758, 54770
Baldwin	St. Croix	54002, 54013, 54015, 54017, 54026, 54027, 54028, 54749, 54767
	Dunn	54749, 54751
Bayfield	Ashland	54850
	Bayfield	54814, 54827, 54844, 54891
Beloit	Rock	53511, 53512
Boscobel	Crawford	53805, 53826, 53831, 54657
	Grant	53518, 53573, 53801, 53804, 53805, 53809, 53816, 53821, 53827
	Richland	53518, 53573
Burnett County	Burnett	Entire county: 54801, 54813, 54830, 54837, 54840, 54845, 54853, 54871, 54872, 54893
Chetek/Colfax	Barron	54004, 54728, 54733, 54757, 54762, 54812, 54889, 54895
	Dunn	54005, 54725, 54730, 54734, 54749, 54751, 54757, 54763, 54772
Chilton/New Holstein/Brillion	Calumet	53014, 53042, 53049, 53061, 53062, 54110, 54129, 54130
Clark County	Clark	Entire county: 54405, 54420, 54421, 54422, 54425, 54436, 54437, 54446, 54456, 54460, 54466, 54479, 54488, 54493, 54498, 54746, 54754, 54768, 54771
Clintonville/Marion	Outagamie	54106, 54170, 54922
	Shawano	54928, 54929, 54950
	Waupaca	54922, 54929, 54949, 54950
Coon Valley/Chaseburg	La Crosse	54619, 54623, 54667
	Vernon	54621, 54623, 54667
Darlington/Schullsburg	Green	53504, 53516
	Lafayette	53504, 53516, 53530, 53541, 53565, 53586, 53587

Appendix 25 (Continued)

HPSA Name	County	ZIP Codes
Durand	Buffalo	54736
	Dunn	54736, 54737, 54739, 54740, 54751, 54755
	Pepin	54721, 54736, 54759, 54769
	Pierce	54740, 54750, 54761, 54767
Eastern Marinette/Southern Menomonie	Marinette	54143, 54157, 54159, 54177
Elcho	Langlade	54424, 54428, 54435, 54462, 54485
	Oneida	54435, 54463
Florence County	Florence	Entire county: 54103, 54120, 54121, 54151, 54542
Forest County	Forest	Entire county: 54103, 54104, 54465, 54511, 54520, 54541, 54542, 54562, 54566
Frederic/Luck	Polk	54829, 54837, 54853
Galesville/Trempealeau	Trempealeau	54612, 54625, 54627, 54630, 54661
Hayward/Radisson	Bayfield	54517, 54821, 54832, 54839, 54873
	Sawyer	54817, 54835, 54843, 54862, 54867, 54876, 54896
	Washburn	54843, 54875, 54876
Hillsboro	Juneau	53929, 53968
	Monroe	53929, 54638, 54648, 54651, 54670
	Richland	53924, 53941, 54634
	Sauk	53968
	Vernon	53929, 53968, 54634, 54638, 54639, 54651
Hurley/Mercer	Iron	54534, 54536, 54545, 54547, 54550, 54559
Kenosha	Kenosha	53140, 53142, 53143, 53144
Kewaunee City/Algoma	Kewaunee	54201, 54205, 54216, 54217
Lancaster/Fennimore	Grant	53569, 53802, 53804, 53806, 53809, 53810, 53813, 53820, 53825
Land O'Lakes/Presque Isle	Vilas	54540, 54547, 54557
Markesan/Kingston	Green Lake	53923, 53926, 53939, 53946, 53947, 53949
Marquette County	Marquette	Entire county: 53920, 53926, 53930, 53949, 53952, 53953, 53954, 54960, 53964, 54982
Menominee County	Menominee	Entire county: 54135, 54150, 54416
Milwaukee	Milwaukee	53203, 53204, 53205, 53206, 53208, 53209, 53210, 53212, 53215, 53216, 53218, 53233

Appendix 25 (Continued)

HPSA Name	County	ZIP Codes
Minong/Solon Springs	Douglas	54820, 54830, 54838, 54849, 54859, 54873
	Washburn	54859, 54875, 54888
Mondovi	Buffalo	54610, 54622, 54736, 54747, 54755
	Pepin	54755
Mountain/White Lake	Langlade	54430, 54465, 54491
	Oconto	54112, 54114, 54138, 54149, 54161, 54174, 54175, 54491
Oconto/Oconto Falls	Oconto	54101, 54124, 54139, 54141, 54153, 54154, 54171, 54174
	Shawano	54127
Platteville/Cuba City	Grant	53554, 53807, 53811, 53818, 53820
	Iowa	53554, 53580
	Lafayette	53510, 53803, 53807, 53811, 53818
Portage/Pardeeville	Columbia	53901, 53911, 53923, 53928, 53932, 53935, 53954, 53955, 53956, 53960, 53969
	Dodge	53956, 53957
Price/Mellen	Ashland	54514, 54527, 54546
	Iron	54552
	Price	Entire county: 54459, 54513, 54514, 54515, 54524, 54530, 54537, 54552, 54555, 54556, 54564
Pulaski	Brown	54162
	Shawano	54162, 54165
	Oconto	54162
Rusk County	Rusk	Entire county: 54526, 54530, 54563, 54728, 54731, 54745, 54757, 54766, 54817, 54819, 54835, 54848, 54868, 54895
Sister Bay/Washington Island	Door	54202, 54210, 54211, 54212, 54234, 54246
Sparta	Monroe	54615, 54619, 54648, 54656
Spooner/Shell Lake	Washburn	54801, 54813, 54817, 54870, 54871, 54875, 54888
Spring Green/Plain	Richland	53556
	Sauk	53556, 53577, 53578, 53583, 53588, 53937, 53943, 53951
Stanley/Cornell	Chippewa	54726, 54727, 54732, 54745, 54757, 54766, 54768
	Eau Claire	54722, 54726, 54742, 54768
Sturgeon Bay	Door	54201, 54202, 54204, 54209, 54213, 54217, 54235

Appendix 25 (Continued)

HPSA Name	County	ZIP Codes
Taylor County	Taylor	Entire county: 54422, 54425, 54433, 54434, 54439, 54447, 54451, 54460, 54470, 54480, 54490, 54498, 54766, 54768, 54771
Tigerton/Birnamwood	Marathon	54408, 54414, 54427, 54429, 54440, 54499
	Shawano	54409, 54414, 54416, 54427, 54450, 54486, 54499
	Waupaca	54486, 54926, 54945
Tomahawk	Lincoln	54435, 54442, 54487, 54501, 54564
	Oneida	54487, 54529, 54564
Wausau, City of	Marathon	54401, 54403
Waushara	Waushara	54909, 54923, 54930, 54940, 54943, 54960, 54965, 54966, 54967, 54970, 54981, 54982, 54984
Western Marinette	Marinette	54102, 54104, 54112, 54114, 54119, 54125, 54151, 54156, 54159, 54161, 54177

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Appendix 26

Clozapine Management

Conditions for Coverage of Clozapine Management

Physicians and physician clinics may be separately reimbursed for clozapine management services when all of the following conditions are met:

- A physician prescribes the clozapine management services in writing if any of the components of clozapine management are provided by the physician or by individuals who are under the general supervision of a physician. Although separate prescriptions are not required for clozapine tablets and clozapine management, the clozapine management service must be identified as a separately prescribed service from the drug itself.
- The recipient is currently taking or has taken clozapine tablets within the past four weeks.
- The recipient resides in a community-based setting (excluding hospitals and nursing homes).
- The physician or qualified staff person has provided the components of clozapine management as described below.

Clozapine is appropriate for recipients with an *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code between 295.10 and 295.95 and who have a documented history of failure with at least two psychotropic drugs. Lithium carbonate may not be one of the two failed drugs. Reasons for the failure may include:

- No improvement in functioning level.
- Continuation of positive symptoms (hallucinations or delusions).
- Severe side effects.
- Tardive dyskinesia/dystonia.

Components of Clozapine Management

The following components are part of the clozapine management service and must be provided, as needed, by the physician or by a qualified professional under the general supervision of the physician:

- Ensure that the recipient has the required weekly or biweekly white blood cell count testing. Recipients must have a blood sample drawn for white blood cell count testing before initiation of treatment with clozapine and must have subsequent white blood cell counts done weekly for the first six months of clozapine therapy.

If a recipient has been on clozapine therapy for six months of continuous treatment and if the weekly white blood cell counts remain stable (greater than or equal to 3,000/mm³) during the period, the frequency of white blood cell count monitoring may be reduced to once every two weeks. For these recipients, further weekly white blood cell counts require justification of medical necessity. Recipients who have their clozapine dispensed every week but who have a blood draw for white blood cell count every two weeks qualify for biweekly, not weekly, clozapine management services.

For recipients who have a break in therapy, white blood cell counts must be taken at a frequency in accordance with the rules set forth in the “black box” warning of the manufacturer’s package insert.

The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. The provider may travel to the recipient’s residence or other places in the community where the recipient is available to perform this service, if necessary. The provider’s transportation to and from the recipient’s home or other community location to carry out any of the required services listed here are considered part of the capitated weekly or biweekly payment for clozapine

Appendix 26 (Continued)

management and is not separately reimbursable. The blood test is separately reimbursable for a Medicaid-certified laboratory.

- Obtain the blood test results in a timely fashion.
- Ensure that abnormal blood test results are reported in a timely fashion to the provider dispensing the recipient's clozapine.
- Ensure that the recipient receives medications as scheduled and that the recipient stops taking medication when a blood test is abnormal, if this decision is made, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being is maintained.
- Make arrangements for the transition and coordination of the use of clozapine tablets and clozapine management services between different care locations.
- Monitor the recipient's mental status according to the care plan. The physician is responsible for ensuring that all individuals having direct contact with the recipient in providing clozapine management services have sufficient training and education. These individuals must be able to recognize the signs and symptoms of mental illness, the side effects from drugs used to treat mental illness, and when changes in the recipient's level of functioning need to be reported to a physician or registered nurse.
- Following record keeping requirements for clozapine management.

Record Keeping Requirements for Clozapine Management

The provider who bills for clozapine management must keep a unique record for each recipient for whom clozapine management is provided. This record may be a part of a larger record that is also used for other services, if the provider is also providing other services to the recipient. However, the clozapine management records must be clearly identified as such and must contain the following:

- A cover sheet identifying the recipient, including the following information:
 - ✓ Recipient's Medicaid identification number.
 - ✓ Recipient's name.
 - ✓ Recipient's current address.
 - ✓ Name, address, and telephone number of the primary medical provider (if different from the prescribing physician).
 - ✓ Name, address, and telephone number of the dispensing provider from whom the recipient is receiving clozapine tablets.
 - ✓ Address and telephone number of other locations at which the client may be receiving a blood draw on his or her own.
 - ✓ Address and telephone number where the recipient can often be contacted.
- A care plan indicating the manner in which the provider ensures that the covered services are provided (e.g., plan indicates where and when blood will be drawn, whether the recipient will pick up medications at the pharmacy or whether they will be delivered by the provider). The plan should also specify signs or symptoms that might result from side effects of the drug or other signs or symptoms related to the recipient's mental illness that should be reported to a qualified medical professional. The plan should indicate the health care professionals to whom oversight of the clozapine management services has been delegated and indicate how often they will be seeing the recipient. The plan should be reviewed every six months during the first year of clozapine use. Reviews may be reduced to once per year after the first year of use if the recipient is stable, as documented in the record.
- Copies of physician's prescriptions for clozapine and clozapine management.
- Copies of laboratory results of white blood cell counts.
- Signed and dated notes documenting all clozapine management services. Indicate date of all blood draws as well as who performed the blood draws. If the provider had to travel to provide services, indicate the travel time. Document services provided to ensure that the recipient received medically necessary care following an abnormal white blood cell count.

Appendix 26 (Continued)

Physicians and physician clinics providing clozapine management services must be extremely careful not to double bill Wisconsin Medicaid for services. This may happen when physicians provide clozapine management services during the same encounter as when they provide other Medicaid-allowable physician services. In these cases, the physician must document the amount of time spent on the other physician service separately from the time spent on clozapine management. Regular psychiatric medication management is not considered a part of the clozapine management services and, therefore, may be billed separately.

Noncovered Clozapine Management Services

Wisconsin Medicaid does not cover the following as clozapine management services:

- Clozapine management for a recipient not receiving clozapine, except for the first four weeks after discontinuation of the drug.
- Clozapine management for recipients residing in a nursing facility or hospital on the date of service.
- Care coordination or medical services not related to the recipient's use of clozapine.

Related Services That Are Reimbursed Separately from Clozapine Management

- *White Blood Cell Count* — The white blood cell count must be performed and billed by a Medicaid-certified laboratory to receive Wisconsin Medicaid reimbursement.
- *Recipient Transportation* — Recipient transportation to a physician's office is reimbursed in accordance with HFS 107.23, Wis. Admin. Code. When provided by a specialized medical vehicle (SMV), such transportation is not covered unless the recipient is certified for SMV services as described in the General Information chapter of this section. Recipient transportation by common carrier must be approved and paid for by the county agency responsible for Medicaid transportation services.

Billing for Clozapine Management

Wisconsin Medicaid reimburses a single fee for clozapine management services provided either once per calendar week (i.e., Sunday through Saturday) or once per two calendar weeks. Providers indicate a quantity of 1.0 for each billing period. For recipients who have weekly white blood cell counts, providers will only be allowed to bill clozapine management once (up to 4.0 units) per week, regardless of the number of services provided during a week. For those recipients who have white blood cell counts taken every other week, providers will only be allowed to bill clozapine management once (up to 4.0 units) every two weeks.

Providers submit claims for clozapine management services using the 837 Health Care Claim: Professional transaction or paper CMS 1500 claim form. For each billing period, only one provider per recipient may be reimbursed for clozapine management with procedure code H0034 (Medication training and support, per 15 minutes) and modifier "UD" (clozapine management).

Billing Units for Clozapine Management Services	
Quantity	Time
1.0	1-15 minutes
2.0	16-30 minutes
3.0	31-45 minutes
4.0	46-60 minutes

Appendix 26 (Continued)

The following table lists the allowable place of service codes that providers of clozapine management services are required to use when submitting claims.

POS Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
22	Outpatient Hospital
34	Hospice
71	State or Local Public Health Clinic
99	Other Place of Service

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Appendix 27

Allowable Temporomandibular Joint Surgery and Anesthesia Procedure Codes and Temporomandibular Joint Evaluation Programs

Temporomandibular Joint Surgery and Anesthesia Procedure Codes	
Service	Codes
Surgery services	20910, 20962, 21010, 21050, 21060, 21070, 21240, 21242, 21243, 29800, 29804
Anesthesia services	00190, 00192, 00470, 01250, 01320, 01470, 01610, 01710, 01810

Temporomandibular Joint Evaluation Programs

The following programs have been approved as multidisciplinary temporomandibular joint evaluation programs for Wisconsin Medicaid.

Medical College of Wisconsin
Oral and Maxillofacial Surgery
9200 W Wisconsin Ave
Milwaukee WI 53226
(414) 454-5760

Gundersen Clinic, Ltd.
1836 South Ave
LaCrosse WI 54601
(608) 782-7300, extension 2260

Oral and Maxillofacial Surgery Associates of Waukesha, Ltd.
1111 Delafield St #321
Waukesha WI 53188
(414) 547-8665

Oral and Maxillofacial Surgery Associates of Green Bay SC
704 Webster Ave
Green Bay WI 54301
(920) 468-3400

University of Wisconsin Hospital and Clinics
600 Highland Ave
Madison WI 53792
(608) 263-7502

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Appendix 28

Certification of Need for Specialized Medical Vehicle Transportation

(A copy of the Certification of Need for Specialized Medical Vehicle Transportation is located on the following pages.)

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WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

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 application 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.

Use an exact copy of this form. Wisconsin Medicaid will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form.

INSTRUCTIONS FOR MEDICAL CARE PROVIDER COMPLETING THIS FORM

Print clearly or type.

Sections I and II

Print the recipient's full name and Wisconsin Medicaid identification number in Section I.

Check yes or no for whether the recipient has a condition that contraindicates safe travel by common carrier such as bus, taxi, or private vehicle. If no, stop here.

Sections III and IV

Complete Sections III and IV if the recipient's condition contraindicates safe travel by common carrier such as bus, taxi, or private vehicle.

Sign and date Section IV only if the provider has evaluated this recipient and finds that he or she is legally blind or disabled and cannot travel safely by common carrier such as a private vehicle or mass transit. The provider's signature must be original and cannot be stamped or photocopied. Give the original form to the recipient and keep a copy. Faxes are acceptable.

Definitions

Indefinitely disabled — As stated in HFS 107.23(1)(c)1, Wis. Admin. Code, "indefinitely disabled" means a chronic, debilitating physical impairment which includes an inability to ambulate without personal assistance or requires the use of a mechanical aid such as a wheelchair, a walker or crutches, or a mental impairment which includes an inability to reliably and safely use common carrier transportation because of organic conditions affecting cognitive abilities or psychiatric symptoms that interfere with the recipient's safety or that might result in unsafe or unpredictable behavior. These symptoms and behaviors may include the inability to remain oriented to correct embarkation and debarkation points and times and the inability to remain safely seated in a common carrier cab or coach.

Temporarily disabled — A condition that meets the above definition but is expected to exist only for a limited time.

INSTRUCTIONS FOR SPECIALIZED MEDICAL VEHICLE PROVIDER

1. Give a copy of this form to the recipient requesting specialized medical vehicle transportation if he or she does not already have a copy. Wisconsin Medicaid will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form.

The form is valid only if it is completed fully and has an original signature (i.e., not a stamped or photocopied signature). Wisconsin Medicaid will not accept incomplete forms or forms without original signatures. Faxes are acceptable.

2. Accept the form only if the date of receipt is within 14 working days from the date the medical care provider signs the form. If the form indicates that the recipient is temporarily disabled, the certification of need is valid for the period indicated on the form. This period must be no more than 90 days from the date the medical care provider signed the form.

If the form indicates that the recipient is indefinitely disabled, the certification of need is valid for 365 days from the date the medical care provider signed the form.

3. Retain the completed original in the recipient's file for five years from the last date of service billed under this form. Failure to retain this form may result in recovery of Medicaid payment for the transportation services the provider provided to the recipient.

**WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION**

All areas of this form must be completed and signed by an evaluator to verify the need for specialized medical vehicle (SMV) transportation. Only a physician, physician assistant, nurse midwife, or nurse practitioner may be an evaluator and sign this form.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient	2. Wisconsin Medicaid Recipient Identification Number
---------------------	---

SECTION II — ELIGIBILITY FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

3. Does the recipient have a medical condition that contraindicates safe travel by common carrier such as bus, taxi, or private vehicle?

- ☐ Yes. Complete Sections III and IV.
- ☐ No. Do **not** complete or sign this form. Instead, refer the recipient to the Medicaid transportation coordinator in his or her county/tribal social or human services department. Please **STOP** here.

Complete all areas in Sections III and IV if this recipient's condition contraindicates safe travel by common carrier.

SECTION III — DIAGNOSIS INFORMATION AND VERIFICATION OF MEDICAL CONDITION

4. I have evaluated this recipient and certify that he or she is (check one):

- ☐ Indefinitely disabled. (See form instructions for a definition.) This form is valid for 365 days from the date signed by the evaluator.
- ☐ Legally blind. This form is valid for 365 days from the date signed by the evaluator.
- ☐ Temporarily disabled. (See form instructions for a definition.) This form is valid for 90 days from the date signed by the evaluator.

State specific condition: _____

State expected duration of disability: _____ days

5. Briefly explain why the recipient's medical condition requires transportation in a specialized medical vehicle:

SECTION IV — MEDICAL CARE PROVIDER INFORMATION

I have evaluated this recipient and certify that he or she has a condition that contraindicates safe travel by common carrier, such as private vehicles or mass-transit services, and requires the use of an SMV for transportation to receive medical services.

6. SIGNATURE — Evaluator	7. Date Signed
8. Name — Evaluator (print)	9. Job Title — Evaluator
10. Wisconsin Medicaid Provider Number (eight digits), license number, or Universal Provider Identification Number (UPIN)	

For questions about form completion or Wisconsin Medicaid, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Appendix 29

Wisconsin Medicaid Newborn Report (for photocopying)

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

Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
NEWBORN REPORT**

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 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 the following address:

Wisconsin Medicaid
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
Name — Contact Person	Telephone Number — Contact Person ()

SECTION II — NEWBORN INFORMATION

Name — Newborn (First, Middle Initial, Last)	Date of Birth (MM/DD/YYYY)
Gender <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, City, State, and Zip Code)
Mother's Recipient Medicaid Identification Number	
Case Head's Recipient Medicaid Identification Number	

SECTION IV — AUTHORIZATION

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

Appendix 30

Declaration of Supervision for Nonbilling Providers Instructions

(A copy of the Declaration of Supervision for Nonbilling Providers Instructions is located on the following pages.)

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Refer to the Online Handbook
for current policy

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WISCONSIN MEDICAID DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS INSTRUCTIONS

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

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

INSTRUCTIONS

Nonbilling providers receive nonbilling provider numbers. The numbers cannot be used independently to bill Wisconsin Medicaid. The following nonbilling providers are required to complete the Declaration of Supervision for Nonbilling Providers form, HCF 1182, for changes in physical address and all supervisor changes:

- Occupational Therapy Assistants.
- Physical Therapist Assistants.
- Physician Assistants.
- Speech Therapists, Bachelor of arts (BA) level.

The nonbilling provider(s) who has changed his or her work address or supervisor should complete Section I. The nonbilling provider's supervisor should complete Section II.

SECTION I — PROVIDER INFORMATION

Name and Credentials — Nonbilling Provider

Enter the nonbilling provider's first name, middle initial, and last name. Also include whether the nonbilling provider is an occupational therapy assistant, physical therapist assistant, physician assistant, or speech therapist, BA level.

Wisconsin Medicaid Provider Number

Enter the nonbilling provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters.

Address — Nonbilling Provider

Enter the nonbilling provider's complete physical work address (street, city, state, and zip code). A post office (P.O.) box number alone is not acceptable.

Telephone Number — Nonbilling Provider

Enter the nonbilling provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Provider Reimbursement Statement

In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Name — Clinic or Supervisor" write the name of the clinic or supervisor where Wisconsin Medicaid will send reimbursement.

Signature — Nonbilling Provider

The signature of the nonbilling provider is required here. Signature stamps and electronic signatures are not acceptable.

Date Signed

Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed. This is a required field.

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor

Enter the supervisor's first name, middle initial, and last name.

Wisconsin Medicaid Provider Number

Enter the supervisor's eight-digit Medicaid identification number, if applicable. Do not enter any other numbers or letters.

IRS Number — Employer

Enter the nine-digit federal tax identification number (Internal Revenue Service [IRS] number) of the supervisor's employer.

Address — Supervisor

Enter the supervisor's complete physical work address (street, city, state, and zip code).

Telephone Number — Supervisor

Enter the supervisor's telephone number, including the area code, of the office, clinic, facility, or place of business.

Supervisor Reimbursement Statement

In the space labeled "Name — Supervisor," write the complete name of the nonbilling provider's supervisor. In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Supervisor's Effective Starting Date," enter the month, day, and year (in MM/DD/YYYY format) when this person began supervising the nonbilling provider's work.

Signature — Supervisor

The signature of the supervisor must appear here. Signature stamps and electronic signatures are not allowed.

Date Signed

Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.

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Appendix 31

Declaration of Supervision for Nonbilling Providers (for photocopying)

(A copy of the Declaration of Supervision for Nonbilling Providers is located on the following page.)

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for current policy

WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS

SECTION I — NONBILLING PROVIDER INFORMATION	
Name and Credentials — Nonbilling Provider	Wisconsin Medicaid Provider Number
Address — Nonbilling Provider	Telephone Number — Nonbilling Provider

I, _____, direct Wisconsin Medicaid to make checks payable to
(Name — Provider)
_____ for all claims payments for services performed by me
(Name — Clinic or Supervisor)
under Wisconsin Medicaid since Wisconsin Medicaid cannot reimburse me.

I understand that this payment arrangement will continue in effect until Wisconsin Medicaid receives a new Declaration of Supervision for Nonbilling Providers form from me. When my supervisor, employer, or work address changes, I will immediately send this completed form to Wisconsin Medicaid.

SIGNATURE — Nonbilling Provider (required)	Date Signed (required)
---	------------------------

SECTION II — SUPERVISOR INFORMATION		
Name — Supervisor	Wisconsin Medicaid Provider Number	Internal Revenue Service (IRS) Number — Employer
Address — Supervisor	Telephone Number — Supervisor	

I, _____, am supervising the work of _____.
(Name — Supervisor) (Name — Provider)

I began supervising the previously listed nonbilling provider on _____. I hereby acknowledge and
(Supervisor's Effective Starting Date)
agree to the above payment arrangement.

I understand that if my name is indicated in Section I above, Wisconsin Medicaid payment for services provided by the nonbilling provider will be payable to me directly and will be reported under the IRS number written above. If I discontinue supervision of the nonbilling provider, I understand that I must notify Wisconsin Medicaid at the address at the bottom of this page.

SIGNATURE — Supervisor	Date Signed
-------------------------------	-------------

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

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.

Appendix 32

Diagnosis-Restricted Provider-Administered Drugs

The following table contains diagnosis-restricted provider-administered drugs and the corresponding diagnosis code and disease descriptions. When a provider-administered drug claim is submitted with a diagnosis listed in this appendix, prior authorization (PA) is not required. For uses outside the listed diagnosis, PA is required. Peer-reviewed medical literature from scientific medical or pharmaceutical publications in which original manuscripts are rejected or published only after having been reviewed by unbiased independent experts to support the proven efficacy of the requested use of the drug is also required to be submitted with the PA request.

Note: This table includes Wisconsin Medicaid's most current information and may be updated periodically.

HCPDS Code*	Drug Name	Diagnosis Code	Disease Description
J0205	Alglucerase (Ceredase)	2727	Gaucher's Disease
J0585	Botulinum Toxin Type A (Botox)	3336	Idiopathic dystonia
		3337	Symptomatic torsion dystonia
		33381	Blepharospasm
		33383	Spasmodic torticollis
		33384	Focal hand dystonia
		34211	Spastic hemiplegia and hemiparesis affecting dominant side
		34212	Spastic hemiplegia and hemiparesis affecting nondominant side
		3440-34404, 34409	Quadriplegia
		3441	Paraplegia
		340	Multiple Sclerosis
		3430-3439	Cerebral palsy
		3518	Facial spasm
		3780-37887	Strabismus
		70521	Hyperhidrosis
		72885	Spasm of muscle
		7810	Hemifacial spasm
J0587	Botulinum Toxin Type B (Myobloc)	33383	Spasmodic torticollis
J0880 and Q4054	Darbepoetin alfa in albumin solution (Aranesp)	042, 07953	Anemia from Acquired Immune Deficiency Syndrome (AIDS)
		140-20491, 230-2386, 2388-2399, 2733	Non-myeloid malignancies or multiple myeloma
		20610	Chronic myelomonocytic leukemia
		2387, 2849, 2850	Myelodysplastic syndrome
		28521	Anemia in end-stage renal disease
		28522	Anemia in neoplastic disease
		585	Chronic renal failure
J1440	Filgrastim (Neupogen), 300 mcg	2880	Agranulocytosis/Neutropenia
J1441	Filgrastim (Neupogen), 480 mcg	2880	Agranulocytosis/Neutropenia
J1595	Glatiramer acetate (Copaxone)	340	Multiple Sclerosis
J1785	Imiglucerase (Cerezyme)	2727	Gaucher's Disease
J1825	Interferon Beta 1A (Avonex)	340	Multiple Sclerosis

Continued

HCPCS Code*	Drug Name	Diagnosis Code	Disease Description
J1830	Interferon Beta 1B (Betaseron)	340	Multiple Sclerosis
J2505	Pegfilgrastim (Neulasta)	2880	Agranulocytosis/Neutropenia
J2820	Sargramostim (Leukine)	205	Myeloid leukemia
J7505	Muromonab CD 3 (Orthoclone OKT-3)	9968	Organ transplant failure or rejection
J9212	Interferon Alfacon 1 (Infergen)	07054	Chronic hepatitis C without mention of hepatic coma
J9213	Interferon Alfa 2A (Roferon-A)	07054	Chronic hepatitis C without mention of hepatic coma
		1729	Malignant melanoma
		1760-1769	Kaposi's sarcoma
		2024	Hairy cell leukemia
		2028	Non-hodgkin's lymphoma
		2030	Multiple myeloma
		2051	Chronic myelocytic leukemia
		2337	Bladder carcinoma
		2339	Renal cell carcinoma
J9214	Interferon Alfa 2B (Intron A)	07054	Chronic hepatitis C without mention of hepatic coma
		07811	Condyloma acuminatum
		1729	Malignant melanoma
		1760-1769	Kaposi's sarcoma
		2024	Hairy cell leukemia
		2028	Non-hodgkin's lymphoma
		2030	Multiple myeloma
		2337	Bladder carcinoma
		2339	Renal cell carcinoma
J9215	Interferon Alfa N3 (Alferon N)	07811	Condyloma acuminatum
J9216	Interferon Gamma 1B (Actimmune)	2881	Chronic granulomatous disease
		75652	Osteopetrosis
Q0136 and Q4055	Epoetin (Epogen and Procrit)	042, 07953	Anemia from Acquired Immune Deficiency Syndrome (AIDS)
		140-20491, 230-2386, 2388-2399, 2733	Non-myeloid malignancies or multiple myeloma
		20610	Chronic myelomonocytic leukemia
		2387, 2849, 2850	Myelodysplastic syndrome
		28521	Anemia in end-stage renal disease
		585	Chronic renal failure
Q3026	Interferon Beta 1A in Albumin (Rebif)	340	Multiple Sclerosis

*HCPCS = Healthcare Common Procedure Coding System

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