Specialized Medical Vehicle Services

ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy

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

Important Telephone Numbers

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

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

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

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

Table of Contents

Preface

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

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

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

Verifying Eligibility

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

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

Handbook Organization

The Specialized Medical Vehicle Handbook consists of the following chapters:

- General Information.
- Covered Services and Related Limitations.
- Prior Authorization.
- Claims Submission.

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

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

Legal Framework of Wisconsin Medicaid and BadgerCare

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

Federal Law and Regulation

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

Wisconsin Law and Regulation

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

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

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

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

Medicaid Fiscal Agent

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

General Information

The Specialized Medical Vehicle Services Handbook includes information for specialized medical vehicle (SMV) providers regarding covered services, reimbursement methodology, and claims submission information.

The policies in the Specialized Medical Vehicle Handbook govern services as defined in ss. 49.46, Wis. Stats., and HFS 101-108, Wis. Admin. Code, including SMV-specific sections. Refer to the Covered Services and Related Limitations chapter of this handbook for an explanation of covered services and related limitations.

Wisconsin Medicaid reimburses SMV providers for transporting recipients with a documented physical or mental disability that prevents them from traveling safely in a common carrier or private motor vehicle to Medicaid-covered services.

General Medicaid Transportation Policy

Wisconsin Medicaid covers three types of transportation for eligible recipients going to and from Medicaid-covered services:

- Common carrier transportation.
- Specialized medical vehicle transportation.
- Ambulance transportation.

Common Carrier Vehicles

Common carrier is any mode of transportation, other than an ambulance or SMV, approved by the county/tribal social or human services department.

Specialized medical vehicle providers should refer recipients without a completed Certification of Need for Specialized Medical Vehicle Transportation form to their county/tribal social or human services department for transportation by common carrier. Recipients without a completed Certification of Need for Specialized Medical Vehicle Transportation form are not eligible for SMV transportation.

Specialized Medical Vehicles

Wisconsin Medicaid reimburses SMV providers for transporting recipients with a documented physical or mental disability that prevents them from traveling safely in a common carrier or private motor vehicle to Medicaid-covered services. Refer to the "Required Documentation for Specialized Medical Vehicle Transportation" section in the Covered Services and Related Limitations chapter of this handbook for information on documenting transportation necessity.

Ambulance Transportation

Wisconsin Medicaid reimburses Medicaid-certified ambulance providers for transporting a Medicaid recipient if the recipient suffers from an illness or injury that prevents him or her from traveling safely by any other means. Refer to the Ambulance Services Handbook for Wisconsin Medicaid's ambulance policy.

Reimbursement

Wisconsin Medicaid reimburses SMV services at the lesser of the following amounts:

- The amount billed by the provider.
- The Medicaid maximum allowable fee.

Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered payment in full.

Provider Certification

Obtaining Specialized Medical Vehicle Certification

The provisions of HFS 105.39, Wis. Admin. Code, and the human service vehicle (HSV) requirements in ch. Trans. 301, Wis. Admin. Code, regulate certification for SMV providers per the Wisconsin Department of Transportation. Providers should contact their Wisconsin State Patrol district office for more information on HSV requirements.

The Wisconsin Medicaid SMV certification packet contains detailed requirements for certification. Providers are required to meet these requirements and report necessary

changes to Wisconsin Medicaid. For more information on becoming certified, or to obtain a certification packet, visit the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* or contact Provider Services at (800) 947-9627 or (608) 221-9883.

Recertification

Wisconsin Medicaid conducts active provider recertification, which requires providers to complete and return recertification packets within a specified time frame. If providers fail to return recertification materials by the stated deadline, their Wisconsin Medicaid certification will end.

Active recertification is initiated by the Department of Health and Family Services and is completed every year to ensure accuracy of Wisconsin Medicaid's provider data and to implement changes in certification requirements. Wisconsin Medicaid will notify providers at least 30 days before the recertification packets are mailed.

As part of Medicaid SMV recertification, all providers must comply with ch. Trans. 301, Wis. Admin. Code.

Provider Responsibilities

Wisconsin Medicaid requires SMV providers to follow the general policy guidelines for all Medicaid providers detailed in the All-Provider Handbook. Refer to the All-Provider Handbook for information regarding:

- Provider sanctions.
- Recipient requests for noncovered services.
- Recipient retroactive eligibility.
- Record-keeping requirements.
- Standards for fair treatment of recipients.
- Other state and federal requirements.

Reporting Changes in the Company

Providers are required to report the following changes to Wisconsin Medicaid *before* they take effect:

- Company name and/or address.
- Company ownership.
- Vehicle insurance carrier or coverage.

Send changes to:

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

Company Name and/or Address

To report a change in company name and/or address, providers are required to complete the Wisconsin Medicaid Provider Change of Address or Status Form. The form can be found in the All-Provider Handbook or on the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* under the provider forms listing.

Company Ownership

In cases of a change in company ownership, HFS 105.02(1), Wis. Admin. Code, requires the prior owner to send notice to Wisconsin Medicaid by the time of the effective date of the change. In accordance with HFS 105.02(2), Wis. Admin. Code, Wisconsin Medicaid will automatically terminate its agreement with the provider in the event of change of ownership. If the new owner wishes to be eligible for Medicaid reimbursement, he or she must submit a new Wisconsin Medicaid certification application.

The new owner must not submit claims under the prior owner's Medicaid provider number. The new owner should request an application for SMV certification 30 days *before* the transfer of ownership occurs to avoid a lapse in payment. This 30-day period allows time for Wisconsin Medicaid to assign a new provider number to the new owner.

In cases of a change in company ownership, HFS 105.02(1), Wis. Admin. Code, requires the prior owner to send notice to Wisconsin Medicaid by the time of the effective date of the change.

Vehicle Insurance Carrier or Coverage

It is the provider's responsibility to report and document changes in vehicle insurance. Providers are also required to ensure that a current Specialized Medical Vehicle Information Chart, or equivalent form, is on file with Wisconsin Medicaid (refer to Appendix 1 of this handbook for a sample form). However, providers do *not* need to send copies of insurance policies that have been renewed if there have been no changes in carrier or coverage.

Providers who change insurance carriers are required to submit the following to Wisconsin Medicaid:

- All the information in the SMV Provider's Vehicle(s) Insurance Documentation Requirements Checklist (refer to Appendix 2 of this handbook for a checklist of the requirements).
- An updated Specialized Medical Vehicle Information Chart.

If insurance coverage changes on any vehicle, providers are required to submit a copy of the new insurance policy or policy amendment to Wisconsin Medicaid.

Wisconsin Medicaid allows SMV providers to transport recipients with a new business vehicle *as soon as* the vehicle is insured and inspected by the Wisconsin State Patrol as required under chs. HFS 105.39 and Trans 301, Wis. Admin. Code.

Vehicles

Wisconsin Medicaid allows SMV providers to transport recipients with a new business vehicle *as soon as* the vehicle is insured and inspected by the Wisconsin State Patrol as required under chs. HFS 105.39 and Trans 301, Wis. Admin. Code. Wisconsin Medicaid *must* receive the inspection and insurance verification documentation within 14 calendar days of the first date of service or providers will have their reimbursement recouped for the trips provided using that new vehicle before Wisconsin Medicaid receives the documentation.

Recipient Information

Recipient Eligibility for Wisconsin Medicaid

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

Refer to the Important Telephone Numbers page at the beginning of this handbook for information on the methods of verifying eligibility. Refer to the All-Provider Handbook for more information about these methods of verifying recipient eligibility.

Special Benefit Categories

Some Medicaid recipients covered under special benefits categories have limited coverage. Medical status codes received through the EVS identify recipients with limited benefits. Providers may refer to the All-Provider Handbook for more information on the different special benefits categories.

Medicaid Managed Care Coverage

The information in this handbook applies to fee-for-service recipients who receive SMV transportation to Medicaid-covered services. Medicaid HMOs may have different policies regarding SMV services for recipients enrolled in a Medicaid HMO. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

Recipient Eligibility Requirements for Specialized Medical Vehicle Services

As stated in HFS 107.23(1)(c)2, 3, and 4, Wis. Admin. Code, Wisconsin Medicaid covers SMV transportation for Medicaid recipients who meet both of the following criteria:

- Need transportation to obtain a Medicaid-covered service.
- Are legally blind or temporarily or indefinitely disabled to the extent that they cannot safely use another type of transportation, as documented in writing by a nurse midwife, nurse practitioner,

physician, or physician assistant. This documentation must be provided on the Certification of Need for Specialized Medical Vehicle Transportation form. This documentation must be renewed annually for recipients who are legally blind or indefinitely disabled. For recipients who are temporarily disabled, the documentation is valid for no more than 90 days from the date the documentation is signed.

In accordance with HFS 107.23(1)(c)1, Wis. Admin. Code, Wisconsin Medicaid defines "indefinitely disabled" as a chronic, debilitating physical impairment which includes an inability to move about without personal assistance or mechanical aids (for example, a wheelchair, 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.

Wisconsin Medicaid does not reimburse for SMV transportation used for any purpose other than transportation to and from Medicaid-covered services. Recipients who do not qualify for SMV transportation should contact their county/tribal social or human services department for assistance with their transportation needs when appropriate.

Temporarily Disabled Recipients

All temporarily disabled recipients (for example, recipients recovering from an accident or illness) are required to have a Certification of Need for Specialized Medical Vehicle Transportation form describing the disability, including a statement regarding the specific problem which prevents the safe usage of common carrier transportation (as stated in HFS 107.23[1][c]3, Wis. Admin. Code) and the expected number of days the recipient will be eligible for SMV transportation.

For temporary disabilities, the Certification of Need for Specialized Medical Vehicle Transportation form is valid for no more than 90 days from the date it was signed. Recipients are required to obtain an updated Certification of Need for Specialized Medical Vehicle Transportation form upon expiration of the form if further transportation is needed. Refer to "Required Documentation for Specialized Medical Vehicle Transportation" in the Covered Services and Related Limitations chapter of this handbook for more information on the Certification of Need for Specialized Medical Vehicle Transportation form.

Copayment

Wisconsin Medicaid requires SMV providers to request copayments from recipients for SMV services. An SMV provider is required to request a copayment of $1.00 for each time a recipient is transported and a base rate is billed, unless the recipient falls under one of the exemptions listed in the All-Provider Handbook. Providers may not deny services to a recipient who fails to make a copayment. For more information on copayments, exemptions, and copayment collection, refer to the All-Provider Handbook.

Wisconsin Medicaid does not reimburse for SMV transportation used for any purpose other than transportation to and from Medicaid-covered services.

Covered Services and Related Limitations

This chapter contains information about covered specialized medical vehicle (SMV) services and their limitations within Wisconsin Medicaid, in accordance with HFS 107.23, Wis. Admin. Code. The topics outlined include:

- Covered services.
- Trip elements.
- Required documentation for SMV transportation.
- Forms used for documenting SMV transportation.
- Noncovered services.

Covered Services

Allowed Destinations

Wisconsin Medicaid covers SMV services if the transportation is to a facility where the recipient receives Medicaid-covered services, and the recipient meets the eligibility requirements listed previously in this handbook.

In accordance with HFS 107.23(3)(b)5, Wis. Admin. Code, Wisconsin Medicaid covers SMV trips to nonmedical facilities only if the recipient receives a Medicaid-covered service at the facility on the date of transport.

Specialized medical vehicle providers are strongly encouraged to obtain verification of the medical nature of the trip for the purpose of a future audit by obtaining a signed statement from the medical service provider or his or her authorized representative. Providers may use the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form (refer to Appendix 6 of this handbook), or its equivalent, and retain this form in their records. Refer to "Required Documentation for Specialized Medical Vehicle Transportation" in this chapter for more information on how to document the medical nature of the trip.

Pharmacies

Wisconsin Medicaid does not cover trips to destinations where a prescription or other medical supplies pick-up is the only Medicaid-covered service. However, SMVs may stop at pharmacies en route to or from Medicaid-covered services to pick up prescriptions. Providers may submit a claim for waiting time if they stop at a pharmacy en route to or from Medicaid-covered services to pick-up prescriptions.

Transportation to Nonmedical Facilities

In accordance with HFS 107.23(3)(b)5, Wis. Admin. Code, Wisconsin Medicaid covers SMV trips to nonmedical facilities only if the recipient receives a Medicaid-covered service at the facility on the date of transport.

Transportation by Cot or Stretcher

Specialized medical vehicle providers may transport recipients on cots or stretchers if they meet all of these criteria:

- A nurse midwife, nurse practitioner, physician, or physician assistant prescribes transportation by cot or stretcher for the recipient (HFS 107.23[1][c]4, Wis. Admin. Code).
- The SMV is equipped with a fastener assembly which secures the cot or stretcher to the side and the floor during transport. The cot or stretcher may not be secured to any door (HFS 107.23[3][b]10, Wis. Admin. Code).
- The recipient is medically stable. The SMV personnel may not monitor or administer any nonemergency medical services or procedures during transport (HFS 107.23[3][b]10, Wis. Admin. Code).

Specialized medical vehicle providers are also required to indicate the use of a cot or stretcher on the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form. Refer to Appendix 6 of this handbook for a copy of the form.

Additional Attendant

In accordance with 107.23(3)(b)3, Wis. Admin. Code, Wisconsin Medicaid covers the services of a second or third SMV attendant if:

- The recipient's condition requires the presence of another person for restraint or lifting (for example, if the recipient is being transported by cot or stretcher).
- The provider has obtained a statement of the appropriateness of the second attendant. The statement must be in writing and must be obtained from the nurse midwife, nurse practitioner, physician, or physician assistant who signed the Certification of Need for Specialized Medical Vehicle Transportation form. The statement may be included on the Certification of Need for Specialized Medical Vehicle Transportation form. Wisconsin Medicaid will not accept the Certification of Need for Specialized Medical Vehicle Transportation form in lieu of a statement.
- The SMV provider retains a copy of the statement in his or her records.

The additional attendant's name must be stated on the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form. Refer to Appendix 6 of this handbook for a copy of this form.

Trip Elements

A trip consists of the distance from the point of recipient pickup to the recipient's destination point. For example, if a recipient is picked up at his or her home and is transported to a clinic, one trip has been completed when the recipient is dropped off at the clinic. Refer to Appendices 17-31 of this handbook for examples of different trips.

Wisconsin Medicaid covers mileage for the *shortest, most direct* route from the point of recipient pickup to the recipient's destination.

Base Rate

The SMV base rate covers the following services:

- Dispatch of the SMV to the recipient pick-up point.
- Escort of the recipient to and from the door of the recipient's pick-up point and his or her drop-off point.
- The first five miles traveled by the SMV beginning at the recipient's pick-up point.

Providers may *not* submit claims for additional charges to Wisconsin Medicaid if they choose to assist a recipient inside the pick-up or drop-off point.

Mileage

"Mileage" is the distance traveled beyond the first five miles included in the base rate.

Unloaded Mileage

"Unloaded mileage" is the distance traveled without a passenger (regardless of whether or not that passenger is a Medicaid recipient) to pick up the recipient for transport to or from Medicaid-covered services. Wisconsin Medicaid reimburses for unloaded mileage under the following circumstances:

- The SMV travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location. Unloaded mileage is *not* reimbursed for travel less than 20 miles.
- Unloaded mileage is reimbursed only once when multiple recipients are being carried on one trip.
- Unloaded mileage is not reimbursed for an SMV returning empty to its home base.

Refer to Appendix 24 of this handbook for an example of a trip with unloaded mileage. Providers are also required to indicate unloaded mileage on the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form.

A trip consists of the distance from the point of recipient pickup to the recipient's destination point.

Multiple Carry Trips

"Multiple carry" refers to the transportation of more than one Wisconsin Medicaid recipient at the same time. Refer to the Claims Submission chapter of this handbook for information on submitting claims for multiple carry trips.

Providers are required to indicate on the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form whether there are multiple riders and the name of the primary rider. Refer to Appendix 21 of this handbook for an example of a multiple carry trip.

Waiting Time

"Waiting time" refers to time spent by the SMV provider waiting for the recipient to return to the vehicle while the recipient receives medical services. Wisconsin Medicaid reimburses for waiting time:

- For only one recipient, even if the driver waits for multiple recipients at one location.
- For up to a maximum of six hours per recipient per date of service (DOS).
- When a second base rate for the return trip for that recipient, or any other recipient for whom the provider waited, is not billed.
- When both a "to" and "from" trip occurs. For example, if an SMV transports a recipient from home to a clinic, waits at the clinic, and then transports the recipient from the clinic to home.

Specialized medical vehicle providers who submit claims for waiting time are required to physically wait at the location where the recipient receives the medical service.

Providers are required to indicate the starting and ending times of any waiting time on the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form. Refer to Appendix 6 of this handbook for a sample form.

Specialized medical vehicle providers who submit claims for waiting time are required to physically wait at the location where the recipient receives the medical service. The provider may not perform any other transports or activities during the waiting time. Refer to Appendix 17 of this handbook for an example of a trip with waiting time.

Required Documentation for Specialized Medical Vehicle Transportation

HFS 106.02(9), Wis. Admin. Code, requires Wisconsin Medicaid providers to maintain adequate documentation to substantiate their claims for reimbursement for at least five years after the date of payment for their services, even if they are no longer Wisconsin Medicaid SMV providers. Providers must prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. In addition to the documentation requirements specified under HFS 106.02(9), Wis. Admin. Code, providers are required to maintain the following information:

- Necessity for SMV transportation.
- Trip information.
- Vehicle information.
- Driver information.

Necessity for Specialized Medical Vehicle Transportation

To document the necessity for SMV transportation, providers are required to maintain a copy of the recipient's Certification of Need for Specialized Medical Vehicle Transportation form. Wisconsin Medicaid requires that the form be completely filled out and signed by a nurse midwife, nurse practitioner, physician, or physician assistant. Refer to the "Forms Used for Documenting Specialized Medical Vehicle Transportation" section of this chapter for more information on the Certification of Need for Specialized Medical Vehicle Transportation form.

Trip Information

Wisconsin Medicaid requires providers to maintain documentation of every transport, including the:

- Date of service.
- Driver's name.
- Name and Medicaid identification number of each person carried.
- Vehicle identification number.

- A statement from the recipient's nurse midwife, nurse practitioner, physician, or physician assistant about the appropriateness of the additional attendant or cot or stretcher (if additional attendant or cot or stretcher are needed).
- Names of additional attendants (if additional attendants are used).
- Beginning and ending times for waiting time and total amount of waiting time (if waiting time occurs).
- Full odometer readings (to the tenth of a mile) from the beginning and end of the trip.
- Pick-up and drop-off addresses and times.
- The type of facility to which the recipient is transported or the reason for the trip.

Refer to the "Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification Form" section of this chapter for more information on forms used to document trip information.

Vehicle Information

Wisconsin Medicaid requires providers to maintain the following vehicle information:

- A copy of the current (approval must be within past 12 months) Wisconsin Department of Transportation (DOT) Motor Bus/Human Service Vehicle Inspection Report (DOT form SP4162) for each vehicle.
- Documentation showing that an assigned driver or mechanic has inspected each vehicle at least every seven days to ensure proper functioning of the vehicle (HFS 105.39[2][b], Wis. Admin. Code). Refer to Appendix 4 of this handbook for a copy of the Weekly Driver's Vehicle Inspection Report that may be used for this documentation.
- A current list of certified vehicles used to transport Medicaid recipients. Refer to Appendix 1 of this handbook for a copy of the Specialized Medical Vehicle Information Chart that may be used to maintain this list.
- Proof of insurance for each vehicle. Refer to Appendix 2 of this handbook for information on proof of insurance for SMVs.

Providers with a new business vehicle may transport recipients *as soon as* the vehicle is insured and inspected by the Wisconsin State Patrol as required under chs. HFS 105.39 and Trans 301, Wis. Admin. Code.

However, Wisconsin Medicaid must receive the inspection and insurance verification documentation within 14 calendar days of the first DOS. If the required documentation is not received within 14 calendar days of the first DOS, providers will have their reimbursement recouped for the trips provided using that new vehicle before Wisconsin Medicaid receives the documentation.

Refer to "Specialized Medical Vehicle Information Chart" in this chapter for more information on how to document vehicle information.

Driver Information

Wisconsin Medicaid requires providers to maintain a current list of all drivers. The list must include the following information for each driver:

- Name and address.
- License number, restrictions (if any), and expiration date.
- License type.

In addition, providers must maintain documentation showing that each driver has received all of the following:

- Red Cross or equivalent training in first aid cardiopulmonary resuscitation (CPR).
- Refresher training in first aid at least every three years and maintains current CPR certification.

Wisconsin Medicaid requires providers to maintain a current list of all drivers.

- Specific instruction in the use of lifts, ramps, and restraint devices.
- Specific instruction on the care of passengers in seizure.

Refer to "Specialized Medical Vehicle Driver Information Chart" in this chapter for more information on how to document driver information.

Forms Used for Documenting Specialized Medical Vehicle Transportation

Appendices 1 and 3-6 of this handbook contain the following forms that can be photocopied and used to record the required information:

- Specialized Medical Vehicle Information Chart.
- Specialized Medical Vehicle Driver Information Chart.
- Weekly Driver's Vehicle Inspection Report.
- Certification of Need for Specialized Medical Vehicle Transportation form.
- Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form.

Providers are required to use an *exact* copy of the Certification of Need for Specialized Medical Vehicle Transportation form exactly as it appears in Appendix 5 of this handbook.

Providers are required to use an *exact* copy of the Certification of Need for Specialized Medical Vehicle Transportation form exactly as it appears in Appendix 5 of this handbook. For all other forms, providers may choose either to use the forms in this handbook or to develop their own. If providers develop their own forms, they must contain all the same elements as the Wisconsin Medicaid versions. Wisconsin Medicaid may recoup payment if providers fail to maintain adequate records to support each claim.

Specialized Medical Vehicle Information Chart

Provision of the information requested on the Specialized Medical Vehicle Information Chart is mandatory, in accordance with HFS 105.39, Wis. Admin. Code. Providers may use the form provided in Appendix 1 of this handbook to document vehicle information or to develop their own form, as long as it contains all the information on the Wisconsin Medicaid version.

Specialized Medical Vehicle Driver Information Chart

The information on the Specialized Medical Vehicle Driver Information Chart is mandatory in accordance with HFS 105.39, Wis. Admin. Code. Providers may use the form provided in Appendix 3 of this handbook to document driver information or they may develop their own form, as long as it contains all the information on the Wisconsin Medicaid version.

Weekly Driver's Vehicle Inspection Report

The information on the Weekly Driver's Vehicle Inspection Report is mandatory, in accordance with HFS 105.39, Wis. Admin. Code. Providers may use the form provided in Appendix 4 of this handbook to document vehicle information or develop their own form, as long as it contains all the information on the Wisconsin Medicaid version.

If providers plan to use their own version of this form, it must be reviewed and approved by Wisconsin Medicaid prior to use. Submit the alternate version of the form to:

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

Wisconsin Medicaid will notify the provider in a letter that Wisconsin Medicaid received and approved the form. An effective date for the alternate version of the form will be included in the letter.

Certification of Need for Specialized Medical Vehicle Transportation Form

All SMV trips require a completed Certification of Need for Specialized Medical Vehicle Transportation form, including nursing home and hospital discharge trips. The Certification of Need for Specialized Medical Vehicle Transportation form is used to verify that, in

the judgement of a medical professional, the Medicaid recipient being transported by SMV truly requires SMV transportation and cannot safely travel by common carrier. Refer to Appendix 5 of this handbook for a copy of the required Certification of Need for Specialized Medical Vehicle Transportation form.

It is the recipient's responsibility to provide the SMV provider with a copy of the Certification of Need for Specialized Medical Vehicle Transportation form. To help explain this responsibility to recipients, SMV providers may photocopy the letter in Appendix 7 of this handbook and distribute it to each recipient.

Form Completion and Maintenance

In order for Wisconsin Medicaid to reimburse SMV providers for services, the providers must maintain a completed Certification of Need for Specialized Medical Vehicle Transportation form in their records for each recipient transported. Refer to Appendix 5 of this handbook for a copy of the required Certification of Need for Specialized Medical Vehicle Transportation form.

A completed Certification of Need for Specialized Medical Vehicle Transportation form is required to be in the recipient's file within 14 working days after the date it is signed and before any claim is submitted (HFS 107.23[1][c]2 and 3, Wis. Admin. Code).

The form requires a signature from one of the following medical care providers:

- Nurse midwife.
- Nurse practitioner.
- Physician.
- Physician assistant.

The medical care provider may approve SMV transportation by telephone. In cases of telephone approval, HFS 107.23(3)(b)1, Wis. Admin. Code, requires that the SMV provider obtain a completed Certification of Need for Specialized Medical Vehicle Transportation form by whichever of the following deadlines comes first:

- Within 10 working days of the medical provider's telephone approval for SMV service.
- Prior to submitting a claim for the SMV service.

Specialized Medical Vehicle Transportation Trip Ticket/ Medical Care Verification Form

Wisconsin Medicaid requires that providers complete a Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form (or equivalent form) for each transport. Completing the medical care verification section on the form is optional. Providers may use the form provided in Appendix 6 of this handbook or develop their own form. If providers choose to develop their own form, it must contain the same information as the Wisconsin Medicaid form. Where odometer readings are requested on the form, providers must use the actual full odometer reading including tenths of a mile. No other mileage calculations such as tripometers, grid maps, or city block calculations etc. will be accepted.

Prescriptions for Extended Travel

Recipients are required to have a prescription from one of the following medical care providers to submit with a prior authorization (PA) request for SMV trips that will have travel beyond the upper mileage limits:

- Chiropractor.
- Dentist.
- Family planning clinic.
- HealthCheck agency.
- Nurse midwife.

A completed Certification of Need for Specialized Medical Vehicle Transportation form is required to be in the recipient's file within 14 working days after the date it is signed and before any claim is submitted (HFS 107.23[1][c]2 and 3, Wis. Admin. Code).

Specialized medical vehicle providers are required to retain a copy of the prescription for extended travel in their records.

- Nurse practitioner.
- Optometrist/optician.
- Physician.
- Physician assistant.
- Podiatrist.

Refer to the Prior Authorization chapter of this handbook for more information on PA to exceed upper mileage limits.

Each separate medical service destination with extended travel requires a separate prescription. The Certification of Need for Specialized Medical Vehicle Transportation form is *not* a prescription for extended travel.

Specialized medical vehicle providers are required to retain a copy of the prescription for extended travel in their records. The prescription *must* be signed by the referring provider. The prescription must specify:

- The name of the health care provider or facility to which the recipient is referred, and the city in which it is located.
- The service being provided.
- The length of time the recipient will need the service. The length of time cannot exceed 365 days for legally blind or indefinitely disabled recipients and cannot exceed 90 days for temporarily disabled recipients.

Noncovered Services

As specified in HFS 107.03 and HFS 107.23, Wis. Admin. Code, Wisconsin Medicaid does not reimburse for:

- Specialized medical vehicle services provided without a valid and completed Certification of Need for Specialized Medical Vehicle Transportation form.
- Transportation of a recipient's personal belongings only.
- Charges for a recipient's failure to cancel a scheduled trip.
- Sales tax.
- Transportation to a location where no Medicaid-covered service was provided at destination or pick-up point.
- Transportation of lab specimens.
- Extra charges for nights, weekends, or holiday services.
- Unloaded miles (when the distance from the SMV dispatch point to the first pick-up point is 20 miles or less).
- Payment for transport of a recipient's relatives, friends, and attendants.
- Payment for transport provided by the recipient's friends or relatives.
- Charges for "excessive mileage" resulting from indirect routes to and from destinations.
- Trips that extend beyond the upper mileage limits without PA. Refer to the Prior Authorization chapter of this handbook for more information on exceeding upper mileage limits.
- Transportation of an ambulatory recipient (except those with mental impairment described in HFS 107.23[1][c]1., Wis. Admin. Code) to a methadone clinic or a physician clinic solely to obtain methadone, drug counseling, or urinalysis.
- Transportation by SMV to a pharmacy to pick up prescriptions or other medical supplies.
- Transportation by SMV solely to compel a recipient to attend therapy, counseling, or any other Medicaid-covered service.

School-Based Services

As stated in 107.36(1)(h), Wis. Admin. Code, Wisconsin Medicaid will not reimburse SMVs for transporting a child to school or another location to receive Individualized Education Program (IEP) medical services when that transportation is in the child's IEP.

An IEP is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with s. 115.787, Wis. Stats. The IEP guides the delivery of special education supports and services for a child with a disability.

When SMV services are in a child's IEP, the child's school district or Cooperative Educational Service Agency is responsible for submitting claims to Wisconsin Medicaid for the service under the school-based services benefit. Wisconsin Medicaid may reimburse SMVs for transporting a child from and to school for a medical appointment, such as a doctor's appointment, when the medical care and transportation are not in the child's IEP.

Prior Authorization

This chapter contains information on:

- Wisconsin Medicaid requirements for prior authorization (PA).
- Specialized medical vehicle (SMV) services requiring PA.
- Prescriptions for extended travel.
- Requesting PA from Wisconsin Medicaid.

General Requirements

Wisconsin Medicaid does not reimburse for services that require PA if the services are provided:

- Without PA.
- Before the grant date on the Prior Authorization Request Form (PA/RF).
- After the expiration date on the PA/RF.

If a recipient requests a noncovered service, including services for which a PA has been denied, then the recipient is responsible for payment only if the provider informs the recipient prior to performing the service that it is a noncovered service and, therefore, the recipient will be responsible for the payment (HFS 104.01[12][c], Wis. Admin. Code).

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

Specialized medical vehicle providers are required to have PA for trips that extend beyond the upper mileage limits *before* delivery of that service.

Services Requiring Prior Authorization

For SMV services that extend beyond the upper mileage limit, SMV providers need a separate PA for transportation to each location. Refer to Appendix 8 of this handbook for PA/RF completion instructions.

Extended Travel

Specialized medical vehicle providers are required to have PA for trips that extend beyond the upper mileage limits *before* delivery of that service.

Over 40 Miles

HFS 107.23(2)(f), Wis. Admin. Code, requires PA for any one-way SMV trip over 40 miles if the trip begins in one of the following counties:

- Brown.
- Dane.
- Fond du Lac.
- Kenosha.
- La Crosse.
- Manitowoc.
- Milwaukee.
- Outagamie.
- Sheboygan.
- Racine.
- Rock.
- Winnebago.

Over 70 Miles

Wisconsin Medicaid requires PA for any one-way SMV trip (SMV mileage or SMV multiple-carry mileage procedure codes) that is over 70 miles if the trip begins in any Wisconsin county other than those listed above.

Hospital or Nursing Home Discharge Trip

Wisconsin Medicaid does not require PA for SMV transportation for a hospital or nursing home discharge trip regardless of mileage. However, the recipient must meet the requirements for SMV services.

Prescriptions for Extended Travel

To obtain PA for an SMV trip that extends beyond the upper mileage limits, Wisconsin Medicaid requires that the recipient have a prescription signed by one of the following provider types:

- Chiropractor.
- Dentist.
- Family planning agency.
- HealthCheck agency.
- Nurse midwife.
- Nurse practitioner.
- Optometrist/optician.
- Physician.
- Physician assistant.
- Podiatrist.

Specialized medical vehicle providers are required to retain a copy of this prescription for extended travel for use in PA requests. The referring health care provider must sign and date the prescription within one year of the date of receipt by Wisconsin Medicaid and specify:

- The 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. The length of time cannot exceed 365 days for legally blind or indefinitely disabled recipients and cannot exceed 90 days for temporarily disabled recipients.

The prescription is required in addition to the Certification of Need for Specialized Medical Vehicle Transportation form. Wisconsin Medicaid will not accept the Certification of Need for Specialized Medical Vehicle Transportation form as a prescription.

Specialized medical vehicle providers determine if PA is needed based on the upper mileage limits. However, Wisconsin Medicaid grants PA for a certain number of DOS, not for a certain number of miles.

Requesting Prior Authorization

Providers may request PA electronically using Specialized Transmission Approval Technology-Prior Authorization (STAT-PA), by fax, or by mail.

STAT-PA Requests

The STAT-PA system allows Wisconsin Medicaid-certified SMV providers to receive PA electronically, rather than by fax or mail.

Providers can access the STAT-PA system through:

- Personal computer.
- Touch-tone telephone.
- The telephone help desk.

The STAT-PA system is available Monday through Friday, 8:00 a.m. to 9:00 p.m. Refer to Appendices 13 and 14 of this handbook for a blank STAT-PA worksheet with step-by-step instructions.

Prior Authorization Requests by Fax or Mail

Providers may submit their PA requests to Wisconsin Medicaid by fax or mail using the PA/RF and Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA). Refer to Appendices 8-12 of this handbook for sample PA forms and completion instructions.

Faxed requests may be submitted to (608) 221-8616. To avoid delayed adjudication, do not fax and mail duplicate copies of the same PA/RFs. Refer to Appendix 15 of this handbook for further guidelines on submitting PAs by fax. Refer to the Prior Authorization section of the All-Provider Handbook for information on PA deadlines and response time.

P Providers may submit their PA requests to Wisconsin Medicaid by fax or mail using the PA/RF and Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA).

Specialized medical vehicle providers may also request PA by mail by sending completed forms to:

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

Providers may order PA forms by writing to:

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

Please specify the type and quantity of forms needed. Reorder forms are included with each shipment; do not reorder by telephone.

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Refer to the Online Handbook
for current policy

Claims Submission

This chapter contains information on claims submission for specialized medical vehicle (SMV) services, including:

- Coordination of benefits.
- Usual and customary fees.
- Claims submission procedures.
- Claim form components.
- How to submit claims for special situations.

Coordination of Benefits

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

Refer to the Claims Submission section of the All-Provider Handbook for more detailed information on services requiring third-party billing, exceptions, and the "Other Insurance Discrepancy Report."

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Usual and Customary Fees

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, Wisconsin Medicaid shall pay the lesser of a provider's usual and customary charge and the maximum allowable fee established by Wisconsin Medicaid. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered payment in full.

Claims Submission Procedures

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements. For more information, refer to the All-Provider Handbook.

Electronic Claims Submission

Specialized medical vehicle providers are required to receive Department of Health and Family Services (DHFS) approval before they may use electronic claims submission. The DHFS requires that all SMV providers be audited before receiving this approval. Once an audit is completed, providers receive a letter from the DHFS notifying them whether or not they are eligible to begin electronic claims submission. If providers are eligible, the letter will contain instructions on how to proceed setting up electronic claims submission.

Providers are encouraged to submit claims electronically if that option is available to them. Electronic claims submission:

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

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic claims submission:

- Refer to the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Unit at (608) 221-4746 and ask to speak with an EMC coordinator.

Providers who currently use the free software and have technical questions should contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claims Submission

Providers submitting paper claims are required to use the CMS 1500 claim form. Refer to Appendices 16-31 of this handbook for completion instructions and sample claims.

Wisconsin Medicaid denies claims for transportation services when providers submit claims on any paper claim form other than the CMS 1500 claim form. Photocopied claims are acceptable for submission as long as the claims are legible. Do not attach documentation to the claim unless it is specifically requested by Wisconsin Medicaid.

Wisconsin Medicaid does not provide the CMS 1500 claim form. Providers may obtain the National CMS 1500 claim form from any vendor who sells federal forms.

To promote accurate processing of paper claims, follow these suggestions:

- Follow the claim form instructions found in this handbook or subsequent *Wisconsin Medicaid and BadgerCare Updates* exactly.
- Supply all data accurately.
- Supply all data in a legible manner on the face of the claim form by printing or typing the information.
- Type claim data.

Mail completed claims to:

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

Claims Submission Deadline

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

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

Follow-Up to Claims Submission

It is the provider's responsibility to initiate follow-up procedures on claims submitted to Wisconsin Medicaid. The Remittance and Status (R/S) Report indicates processed claims either as paid, pending, or denied.

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

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

Claim Form Components

County Codes

Specialized medical vehicle providers are required to enter a county code in Element 21 of the CMS 1500 claim form for all trips over 40 miles one way. The county code identifies the *point of origin* of the trip and is used to determine which mileage limit applies to the claim during processing. Refer to Appendix 34 of this handbook for a list of county codes.

Place of Service Codes

All transportation claims are required to have the appropriate place of service (POS) code. Place of service codes describe the SMV's destination. Refer to Appendix 32 of this handbook for a list of allowable POS codes.

Procedure Codes

Wisconsin Medicaid requires designated codes on all CMS 1500 claims. Wisconsin Medicaid does not reimburse for claims or adjustments received without proper procedure codes. Refer to Appendix 32 of this handbook for a list of allowable procedure codes and their descriptions.

Wisconsin Medicaid must receive properly completed claims within 365 days from the date of service (DOS).

Wisconsin Medicaid covers trips for the second and additional recipients under the multiple carry base and mileage procedure codes.

Base Rate

Providers are required to use W9096 (standard trip) or W9097 (multiple carry) to submit claims for base rates. Refer to Appendix 32 of this handbook for more information on procedure codes. Refer to Appendices 17-31 for examples of properly completed claims for base rates.

Mileage

Providers may use procedure code W9090 (standard mileage) or W9091 (multiple carry) to submit charges for additional mileage over the base rate. Refer to Appendix 32 for more information on procedure codes used for SMV transportation.

Waiting Time

Providers are required to use procedure code W9095 to submit claims for waiting time. Refer to Appendix 32 of this handbook for more information on procedure codes. Refer to Appendix 18 for an example of a properly completed claim for two trips with waiting time.

Second or Third Attendant

Providers are required to use procedure code W9098 to submit claims for a second attendant. Refer to Appendix 32 of this handbook for more information on procedure codes. Refer to Appendices 19 and 20 for an example and a properly completed claim for two trips with a second attendant.

Unloaded Mileage

Providers are required to use procedure codes appropriate for the amount of unloaded mileage traveled. Refer to Appendix 32 of this handbook for a list of procedure codes for unloaded mileage. Refer to Appendix 25 for an example of a properly completed claim for unloaded mileage.

Modifiers

All SMV procedure codes require two modifiers in Element 24D of the CMS 1500 claim form:

- Number of trip modifiers. Use the trip modifier codes "11" through "20" to identify procedure codes related to the same trip for the same recipient by the same provider on the same DOS.
- Service-provided modifiers. Use the service-provided modifiers to indicate the Medicaid-covered medical service to which the recipient is being transported.

Refer to Appendix 33 of this handbook for a list of allowable modifier codes and information on how to use them.

Special Situations

Multiple Carry Trips

Wisconsin Medicaid covers trips for the second and additional recipients under the multiple carry base and mileage procedure codes. Wisconsin Medicaid covers only the most direct route (i.e., the shortest distance) between the recipient pick-up points and the destination.

If providers transport more than one recipient at the same time, Wisconsin Medicaid will reimburse for only one recipient at the regular base rate (W9096) and mileage (W9090). Wisconsin Medicaid will reimburse for any additional recipients at the multiple carry base rate (W9097) and mileage (W9091).

If transportation is provided to multiple recipients and multiple destinations using direct routes, the provider may choose the recipient with the greatest total mileage to bill at the standard rates. Refer to Appendices 21-23 of this handbook for claim examples of a multiple carry trip.

Nursing Home or Hospital Discharge Trips

Specialized medical vehicle claims for transportation of a recipient due to a nursing home or hospital discharge:

- Do not require a referring physician's Universal Provider Identification Number or Wisconsin Medicaid provider number.
- Require description code G11 in Element 21 of the CMS 1500 claim form. Refer to Appendix 33 for a definition of description code G11.
- Do not require a prior authorization number, regardless of the mileage.

Appendix

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for current policy

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for current policy

Appendix 1
Specialized Medical Vehicle Information Chart
(for photocopying)

(A copy of the Specialized Medical Vehicle Information Chart is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1300A (Rev. 07/03)

STATE OF WISCONSIN
HFS 105.39, Wis. Admin. Code

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE INFORMATION CHART COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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 shall 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 services.

Provision of the information requested on this form is mandatory. However, the use of this version of the form is voluntary, and providers may develop their own form as long as it includes all the information on this form.

- Providers may not use any vehicle not insured by their own specialized medical vehicle (SMV) policy; borrowing vehicles is not allowed.
- All vehicles are required to be equipped/fitted with a wheelchair ramp or lift.
- Providers may not use a vehicle unless it has been inspected at least every seven days, and those inspections have been documented.
- For more information on SMV documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

INSTRUCTIONS

1. Type or print clearly.

2. Before completing this form, make a copy of it for use in reporting any future changes. Providers should retain a copy of the completed form in their records.

3. Prior to any change in vehicles, send an updated copy of this form to:

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

   If a new vehicle is added, submit this form within 14 calendar days.

4. Send correct and complete insurance documentation to Wisconsin Medicaid Provider Maintenance immediately when changing insurance carriers or policies and attach a new, completed copy of this form.

5. Attach a current (approval must be within past 12 months) copy of the Wisconsin Department of Transportation (DOT) Motor Bus/Human Service Vehicle Inspection Report (DOT form SP4162) for each vehicle listed.

6. Under the box labeled “Vehicle Identification,” enter the vehicle identification number (VIN) for each SMV.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1300 (Rev. 07/03)

STATE OF WISCONSIN
HFS 105.39, Wis. Admin. Code

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE INFORMATION CHART

Name — Specialized Medical Vehicle (SMV) Company	Address — SMV Company (Street, City, State, and Zip Code)	Wisconsin Medicaid Provider Number (eight digits)

Vehicle Identification	License Plate Number	Registration Date (MM/DD/YY)	Vehicle Year (YYYY)	Vehicle Make	Vehicle Model	Ramp (Yes / No)	Lift (Yes / No)	Cot / Stretcher (Yes / No)
1.								
2.								
3.								
4.								
5.								
6.								

Name(s) — Assigned Driver(s) or Mechanic(s) Completing Vehicle Inspections	Day of Week Inspections Are Completed	Name(s) — Assigned Driver(s) or Mechanic(s) Completing Vehicle Inspections	Day of Week Inspections Are Completed
1.		3.	
2.		4.	

I affirm that the vehicles listed on this form meet HFS 107.23 and 105.39, Wis. Admin. Code, requirements for a human services vehicle serving the disabled and elderly.

SIGNATURE — Person Completing Form	Name — Person Completing Form (print)	Job Title	Date Signed

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

Appendix 2
Wisconsin Medicaid Specialized Medical Vehicle Provider's Vehicle(s) Insurance Documentation Requirements Checklist

Insurance Documentation Requirements

As part of the certification application, new specialized medical vehicle (SMV) providers must submit insurance documentation detailed in the checklist of this appendix. Currently certified SMV providers are required to submit complete insurance documentation *immediately* when there has been a change in their insurance carrier/agency or when a new replacement insurance policy (excluding a renewal for the same policy) has been issued. Specialized medical vehicle providers are required to submit the following information to Wisconsin Medicaid for approval:

- Copy of the current vehicle's/vehicles' commercial insurance policy (certificates of insurance are not acceptable).
- Completed current Wisconsin Medicaid Specialized Medical Vehicle Information Chart (refer to Appendix 1 of this handbook for a sample form).
- Letter of receipt of payment from the insurance company.

It is the responsibility of the provider, not the insurance agency, to ensure that Wisconsin Medicaid receives the complete insurance documentation by the due date. Providers should give their insurance representative a copy of the checklist so that he or she is familiar with the specific requirements. To avoid delays in approval by Wisconsin Medicaid, providers should review the insurance documentation for accuracy before submitting it.

Submit insurance information to:

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

Temporary Certification Requirements

Wisconsin Medicaid grants temporary certification to the SMV providers who submit an insurance binder which documents all the information required in Section A of the checklist of this appendix. Temporary certification is granted to new providers or to currently certified providers who change their insurance carrier/agency or obtain a new replacement policy. Temporary certification is limited to a maximum of 60 days from the effective date on the binder or the specified binder expiration date, whichever comes first. Wisconsin Medicaid determines the length of a new or reinstated provider's temporary certification by the initial certification or reinstatement effective date. For example: The initial certification or reinstatement date assigned is May 15 and the insurance binder is valid May 1 to June 30. Wisconsin Medicaid approves the temporary certification from May 15 to June 30 or 46 days.

Specialized medical vehicle providers are required to send a copy of their final insurance policy which documents all the information in Section A of the checklist of this appendix. Wisconsin Medicaid must receive the policy before the temporary certification ends, or Wisconsin Medicaid cancels the provider number. The provider number remains canceled until Wisconsin Medicaid receives the documentation; this causes a lapse in certification. The date that Wisconsin Medicaid receives the acceptable insurance documentation is the date of the SMV provider's certification reinstatement. Wisconsin Medicaid will not pay claims with dates of service (DOS) during the period of lapsed certification. Specialized medical vehicle providers are responsible to ensure that Wisconsin Medicaid receives a copy of the actual acceptable policy before their temporary certification expires to avoid a lapse in certification.

Changes in Coverage

Wisconsin Medicaid prohibits SMV providers from transporting Medicaid recipients in any vehicle not covered under the terms of the commercial insurance policy on file with Wisconsin Medicaid. Substitution of vehicles is not allowed. Before using any vehicle that is not on file with Wisconsin Medicaid, the following information must be submitted to Wisconsin Medicaid for approval:

- A copy of the amended insurance policy or changed endorsement with the vehicle identification number (VIN) of each additional vehicle.
- An updated Specialized Medical Vehicle Information Chart.
- Motor/Bus Human Service Vehicle Inspection Report (Department of Transportation [DOT] form SP4162).

When Wisconsin Medicaid receives a cancellation notice from an SMV provider's insurance carrier/agency, Wisconsin Medicaid sends a sanction notice to the provider. It states that the provider's number will be canceled in 20 days if Wisconsin Medicaid does not receive notice of reinstatement without a lapse from the same carrier/agency (for the same policy) or complete documentation of insurance from the provider. The provider number remains canceled until Wisconsin Medicaid receives the documentation; this causes a lapse in certification. The date on which Wisconsin Medicaid receives the acceptable insurance documentation is the date the SMV provider's certification is reinstated. This date is now the assigned reinstatement date. Wisconsin Medicaid will not reimburse claims with DOS during the period of lapsed certification.

Specialized Medical Vehicle Insurance Documentation Checklist

Please carefully read the information on the first two pages. *All* new and reinstated SMV providers are required to send the completed insurance documentation as detailed below. Currently certified SMV providers who change their insurance carrier/agency or obtain a new replacement policy are required to *send it immediately* to Wisconsin Medicaid. Attach the policy to a current Vehicle Chart(s) and send it to the Wisconsin Medicaid address listed at the end of Section A of this appendix. All of the policy items in Section A of this appendix must be contained in the policy and binder if submitted first. All items of the letter of receipt in Section B of this appendix must be included in the letter.

A. Copy of Specialized Medical Vehicle's/Vehicles' Current Commercial Insurance Policy Must Contain:

1) ___ Insurance company name.

2) ___ Amount of personal liability for each person (minimum $250,000).

3) ___ Amount of total personal liability for each occurrence (minimum $500,000).

4) ___ Amount of property damage insurance on *each* SMV (minimum $10,000). Exception: A combined single limit (CSL) policy with a minimum of $500,000 will be accepted. The separate $10,000 property requirement will be administratively waived, without a waiver request, *only* for CSL policies with a minimum liability of $500,000.

5) ___ Name of insured: This must be a commercial policy, not a personal policy, in the SMV business name (the name on the policy must exactly match the SMV business name on all Medicaid documents and/or the Medicaid file).

6) ___ All vehicles used for Medicaid transports must be listed on the current Specialized Medical Vehicle Information Chart(s) and the policy (binder too, if submitted first). The VINs on the binder and policy must *exactly* match the VINs on the current Specialized Medical Vehicle Information Chart(s). Attach a completed current Specialized Medical Vehicle Information Chart.

7) ___ Effective dates of current period of coverage.

8) ___ Additional insured or notification endorsement is required. This is required so that the insurer guarantees to notify Wisconsin Medicaid prior to a policy cancellation. The following must be included in the policy (and binder, if submitted first) and on all policy renewals:

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

B. Letter of Receipt of Payment for Current Vehicle's/Vehicles' Insurance Must:

1) ___ Be from the insurance company on the insurance company's letterhead.

2) ___ Include holder (insured SMV Medicaid provider) name and policy number.

3) ___ Include effective dates of current period of coverage.

4) ___ Include date of payment of current policy premium.

5) ___ Indicate whether this is for a binder or an actual policy.

6) ___ Include the insurance representative's signature and date; initials or signature stamps are not accepted.

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Appendix 3
Specialized Medical Vehicle Driver Information Chart (for photocopying)

(A copy of the Specialized Medical Vehicle Driver Information Chart is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1301A (Rev. 07/03)

STATE OF WISCONSIN
HFS 105.39, Wis. Admin. Code

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE DRIVER INFORMATION CHART COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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 services.

Provision of the information requested on this form is mandatory. However, the use of this version of the 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. For each driver, attach to this form a copy of the current first aid card verifying completion of a basic Red Cross first aid course or its equivalent. The date of the training must be within 36 months of when Wisconsin Medicaid receives this correctly completed form and the effective date of the driver's certification or recertification.

3. For each driver, attach to this form a copy of the cardiopulmonary resuscitation (CPR) card verifying completion of CPR training. The CPR certification must be current when Wisconsin Medicaid receives this correctly completed form and the effective date of the driver's certification or recertification.

4. Wisconsin Medicaid will accept a copy of health care licenses (such as emergency medical technician, registered nurse, nurse practitioner, or physician assistant) as verification of first aid and CPR training if the license is accompanied by dated verification of recent continuing education that includes first aid and CPR instruction.

5. If either the first aid or CPR card does not include the training date, providers are required to attach a signed letter from the instructor, or the instructor's agency, that verifies the training date.

6. In the box marked "Type," fill in "R" for a regular driver's license or a "C" for a commercial license.

7. Providers should retain a copy of this completed form in their records for five years. The form must be updated any time there is a change in drivers.

8. For more information on specialized medical vehicle documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1301 (Rev. 07/03)

STATE OF WISCONSIN
HFS 105.39, Wis. Admin. Code

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE DRIVER INFORMATION CHART

Name — Specialized Medical Vehicle (SMV) Company	Address — SMV Company (Street, City, State, and Zip Code)	Wisconsin Medicaid Provider Number (eight digits)

Name — Driver (Print)	Driver's License			Training Dates (MM/DD/YYYY)			
	Number and Expiration Date (MM/DD/YYYY)	Type	Restrictions (list all)	First Aid Course Name and Date	CPR	Ramp/Lift/ Restraint	Seizure
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

By signing this form, I affirm that I have reviewed the information on this form and found it to be correct.

SIGNATURE — Person Completing Form	Name — Person Completing Form (print)	Position Title	Date Signed

Appendix 4
Weekly Driver's Vehicle Inspection Report (for photocopying)

(A copy of the Weekly Driver's Vehicle Inspection Report is located on the following pages.)

WISCONSIN MEDICAID

WEEKLY DRIVER'S VEHICLE INSPECTION REPORT COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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 services.

Provision of the information requested on this form is mandatory. However, the use of this version of the 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. Indicate, using "yes" or "no," if each item was inspected before the trip and was functioning during the trip. If an item did not function properly, explain the defect in the remarks section.

2. If a provider plans to use an alternate version of this form, it must be reviewed and approved by Wisconsin Medicaid prior to use. Submit the alternate version of the form to:

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

Wisconsin Medicaid will notify the provider in a letter that Wisconsin Medicaid received and approved the form. An effective date for the alternate version of the form will be included in the letter.

3. This form, or an equivalent version, and a vehicle inspection must be completed every seven days for every vehicle.

4. Providers should retain a copy of the completed form in their records for 12 months.

5. In the box labeled "Vehicle Identification," enter one of the following:

- Vehicle identification number (VIN).
- License plate number.

6. For more information on specialized medical vehicle documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1302 (Rev. 07/03)

STATE OF WISCONSIN
HFS 105.39, Wis. Admin. Code

WISCONSIN MEDICAID

WEEKLY DRIVER'S VEHICLE INSPECTION REPORT

Name — Specialized Medical Vehicle (SMV) Company	Wisconsin Medicaid Provider Number (eight digits)	Vehicle Identification	Odometer Reading

Item	Inspected Before Trip (Yes / No)	Functioned During Trip (Yes / No)	Date Corrected (MM/DD/YYYY)	Remarks
Doors				
Wheels, nuts				
Tires — Properly inflated, minimum 1/8 inch tread				
Gas cap				
Engine				
Starter				
Alternator gauge				
Transmission				
Clutch				
Oil Pressure				
Gas gauge				
Lights: • Head. • Tail. • Emergency flashers. • Brake. • Stop arm. • Directionals / Turn Signals. • Hazard. • Clearance. • Interior / Internal.				
Exhaust				
Mirrors				
Brakes				
Steering — Horn				
Wipers — Washers				
Heater — Defrost				
Front suspension				
Steering mechanisms				
Shock absorbers				
Speedometer				

Name — SMV Company	Wisconsin Medicaid Provider Number (eight digits)	Vehicle Identification	Odometer Reading

Item	Inspected Before Trip (Yes / No)	Functioned During Trip (Yes / No)	Date Corrected (MM/DD/YYYY)	Remarks
Steps / Floors / Seats				
Restraint systems: • Driver. • Passenger. • Wheelchair locking systems (wheelchair and passenger secured). • Cot / Stretcher (cot or stretcher and passenger secured).				
Window, windshield, and mirrors: • Clean / Clear vision. • No cracks or breaks.				
Fire extinguisher				
Reflectors or flares				
Working flashlight				
First aid kit				
Accident package				
Working two-way radio or mobile telephone				
Lift / Ramp				
"No smoking" sign present				
Emergency telephone numbers (posted clearly on dashboard)				
Structural integrity of passenger compartment				
Air conditioning system				

ADDITIONAL REMARKS

By signing this form, I affirm that I have inspected all items on this report and found them as noted.

SIGNATURE — Driver / Mechanic	Name — Driver / Mechanic (print)	Date Signed
SIGNATURE — Driver / Fleet Supervisor Reinspecting Vehicle After Corrections Have Been Made	Name — Driver / Fleet Supervisor Reinspecting Vehicle (print)	Date Signed

Appendix 5
Certification of Need for Specialized Medical Vehicle Transportation Form (for photocopying)

(A copy of the Certification of Need for Specialized Medical Vehicle Transportation form is located on the following page.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1197A (Rev. 03/03)

STATE OF WISCONSIN
HFS 107.23, Wis. Admin. Code

WISCONSIN MEDICAID

CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the 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.

Refer to the Specialized Medical Vehicle Handbook for related instructions.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1197 (Rev. 03/03)

STATE OF WISCONSIN
HFS 107.23, Wis. Admin. Code

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 (10 digits)

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 6
Specialized Medical Vehicle Transportation Trip Ticket / Medical Care Verification Form (for photocopying)

(A copy of the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form is located on the following pages.)

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WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE TRANSPORTATION TRIP TICKET / MEDICAL CARE VERIFICATION COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and 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 services.

Provision of the information requested on this form is mandatory. However, the use of this version of the 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. Providers may use this form or an equivalent version. If providers use their own version, it must contain the same elements as the Wisconsin Medicaid version.

3. Wisconsin Medicaid requires a completed trip ticket for each transport.

4. In the box labeled “Vehicle Identification,” one of the following must be entered:

   - Vehicle identification number (VIN).
   - License plate number.
   - Locally assigned number.
   - Human service vehicle company or fleet number.

5. Specialized medical vehicle (SMV) providers are responsible for verifying that a recipient is eligible for Wisconsin Medicaid at the time the transportation is provided.

6. Where odometer readings are requested, providers must use the actual odometer reading, including tenths of a mile. No other mileage calculations, such as grid maps or city block calculations, will be accepted.

7. Specialized medical vehicle providers may obtain documentation of the medical nature of the destination for their records by having the medical service provider sign this form in the space provided in the area marked “SIGNATURE — Person Verifying Medicaid-Covered Service.”

8. For more information on SMV documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1050 (Rev. 07/03)

STATE OF WISCONSIN
HFS 107.23, Wis. Admin. Code

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE TRANSPORTATION TRIP TICKET / MEDICAL CARE VERIFICATION

Name — Specialized Medical Vehicle Company	Wisconsin Medicaid Provider Number (eight digits)	Vehicle Identification	Date of Trip (MM/DD/YY)

SIGNATURE — Driver	Name — Driver	Date Signed

Name — Recipient	Recipient Medicaid Identification Number (10 digits)	Wheelchair?	Cot or Stretcher?
		☐ Yes ☐ No	☐ Yes ☐ No

Name — Second Attendant	Multiple Riders?	Name — Primary Rider
	☐ Yes ☐ No	

Address — Dispatch Location (Street, City, State, and Zip Code)	Odometer Readings for Unloaded Mileage	Name — Medical Facility
	_____ Start _____ End	

Type or Name of Facility or Reason for Trip	Waiting Time — Start	Waiting Time — End
	a.m. / p.m.	a.m. / p.m.

Address — Pick-Up Point (Street, City, State, and Zip Code)	Odometer Reading — Trip Start	Trip Start Time
		a.m. / p.m.

Address — Drop-Off Point (Street, City, State, and Zip Code)	Odometer Reading — Trip End	Trip End Time
		a.m. / p.m.

VERIFICATION OF MEDICAID-COVERED MEDICAL CARE (The information below is optional)

SIGNATURE — Person Verifying Medicaid-Covered Service	Date Signed

Name — Person Verifying Medicaid-Covered Service	Position Title

Name — Specialized Medical Vehicle Company	Wisconsin Medicaid Provider Number (eight digits)	Vehicle Identification	Date of Trip (MM/DD/YY)

SIGNATURE — Driver	Name — Driver	Date Signed

Name — Recipient	Recipient Medicaid Identification Number (10 digits)	Wheelchair?	Cot or Stretcher?
		☐ Yes ☐ No	☐ Yes ☐ No

Name — Second Attendant	Multiple Riders?	Name — Primary Rider
	☐ Yes ☐ No	

Address — Dispatch Location (Street, City, State, and Zip Code)	Odometer Readings for Unloaded Mileage	Name — Medical Facility
	_____ Start _____ End	

Type or Name of Facility or Reason for Trip	Waiting Time — Start	Waiting Time — End
	a.m. / p.m.	a.m. / p.m.

Address — Pick-Up Point (Street, City, State, and Zip Code)	Odometer Reading — Trip Start	Trip Start Time
		a.m. / p.m.

Address — Drop-Off Point (Street, City, State, and Zip Code)	Odometer Reading — Trip End	Trip End Time
		a.m. / p.m.

VERIFICATION OF MEDICAID-COVERED MEDICAL CARE (The information below is optional)

SIGNATURE — Person Verifying Medicaid-Covered Service	Date Signed

Name — Person Verifying Medicaid-Covered Service	Position Title

Appendix 7
Recipient Letter
(for photocopying)

(A copy of the Recipient Letter is located on the following page.)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

James E. Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING
WISCONSIN MEDICAID AND BADGERCARE
RECIPIENT SERVICES
6406 BRIDGE ROAD
MADISON WI 53784
Telephone: 800-362-3002
TTY: 800-362-3002
FAX: 608-221-8815
www.dhfs.state.wi.us/medicaid
www.dhfs.state.wi.us/badgercare

Dear Wisconsin Medicaid Recipient:

Wisconsin Medicaid covers SMV transportation for recipients with a documented physical or mental disability that prevents them from traveling safely in a common carrier or private motor vehicle to Medicaid-covered services. Recipients who are able to safely travel by common carrier should contact their county/tribal social or human services department.

Please give this letter and the Certification of Need for Specialized Medical Vehicle Transportation form to your physician, physician assistant, nurse practitioner, or nurse midwife to be completed and signed as soon as possible. In order to receive SMV services, you will need a completed and signed form. After the form is completed and signed, return it to your SMV provider.

State law requires that the Certification of Need for Specialized Medical Vehicle Transportation forms be renewed upon expiration. Wisconsin Medicaid will not be able to pay your SMV provider for your SMV services without this current Certification of Need for Specialized Medical Vehicle Transportation form.

Thank you for your cooperation.

Appendix 8
Prior Authorization Request Form (PA/RF) Completion Instructions

Wisconsin Medicaid processes prior authorization (PA) requests more quickly when providers include complete, readable, and accurate documentation with the requests. Complete this form carefully, attach the Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA) to it, and mail it to:

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

Providers may also submit PA requests by fax at (608) 221-8616.

Contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 with questions on completing the Prior Authorization Request Form (PA/RF) or PA/SMVA.

Element 1 — Processing Type
Enter the processing type 999. The "processing type" is a three-digit code used to identify a category of service requested.

Element 2 — Recipient's Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient's Address
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 5 — Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

Element 6 — Sex
Enter an "X" to specify male or female.

Element 7 — Billing Provider's Name, Address, and ZIP Code
Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider's Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary
Enter procedure code 00025.

Note: 00025 is a generic procedure code that providers are required to use only to request PA. Providers must follow the claim completion instructions and use the actual diagnosis codes for the CMS 1500 claim form. Wisconsin Medicaid does not reimburse claims submitted with diagnosis code 00025.

Element 11 — Dx: Secondary (not required)

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx
Enter the first date of service in MM/DD/YYYY format.

Element 14 — Procedure Code(s)
Enter procedure code 00025.

Note: Procedure code 00025 is a generic code that providers are required to use only to request PA. Providers will use the actual single or multiple-carry procedure codes to bill for the PA trip on the CMS 1500 claim form. Wisconsin Medicaid does not reimburse claims submitted with procedure code 00025.

Element 15 — MOD
Enter one of the following modifiers for the procedure requested. Wisconsin Medicaid requires a separate prescription and separate PA request for each of the following service modifiers.

Service-Provided Modifiers
(required in Element 24D on the CMS 1500 claim form)

Modifier	Definition	Modifier	Definition	Modifier	Definition
TB	Chiropractor	TH	Therapy (includes physical therapy, occupational therapy, speech therapy, and audiology)	TO	Methadone clinic
TC	Case management, prenatal care coordination	TI	Dialysis	TR	Rehabilitation agency
TD	Dental	TL	Mental health, community support program	TS	Hospital services
TE	Medical equipment supplier/ hearing instrument specialist	TM	Medical services by a physician, nurse practitioner, physician assistant, nurse midwife or family planning clinic, HealthCheck, rural health, podiatry, vision, or ambulatory surgery center		

Element 16 — POS
Enter the appropriate Medicaid single-digit place of service (POS) code designating the trip's destination. Refer to Appendix 32 of this handbook for a list of POS codes.

Element 17 — TOS
Enter type of service code "9." Refer to Appendix 32 of this handbook for a description of this TOS code.

Element 18 — Description of Service
Enter "specialized medical vehicle (SMV) mileage."

Element 19 — Quantity of Service Requested
Enter the number of calendar days ordered on the prescription by the referring health care provider. For example, if the medical provider indicates the length of time in weeks, multiply the weeks by seven and enter the number of days. If the Medicaid provider indicates the time in months, multiply the months by 30 and enter the number of days.

Element 20 — Charges (not required)

Element 21 — Total Charge (not required)

Element 22 — Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is 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, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the HMO.

Element 23 — Date
Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24—Requesting Provider's Signature
The signature of the provider requesting the service must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS. SUBMIT THE PA/RF WITH A COMPLETED PA/SMVA.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 9
Sample Prior Authorization Request Form (PA/RF)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 999

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: 00025

11 DX: SECONDARY:

12 START DATE OF SOI:

13 FIRST DATE RX: 3-31-2002

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
00025	TH	3	9	SMV Mileage	60	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. 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 authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 10
Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA) Completion Instructions

Wisconsin Medicaid usually processes prior authorization (PA) requests more quickly when providers include complete, readable, and accurate documentation with the requests. Complete this form carefully, attach it to the Prior Authorization Request Form (PA/RF), and mail it to:

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

Providers may also submit PA requests by fax at (608) 221-8616.

Contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 with questions on completing the PA/RF or Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA).

Recipient Information

Elements 1-3 — Recipient's Last Name, First Name, Middle Initial

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

Element 4 — Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number.

Element 5 — Age

Enter the recipient's age in numeric form (e.g., 21, 45, 60).

Provider Information

Element 6 — Performing Provider's Name

Enter the name of the specialized medical vehicle company providing the service.

Element 7 — Performing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the SMV company providing the service.

Element 8 — Performing Provider's Telephone Number

Enter the telephone number, including area code, of the SMV company providing the service.

The SMV company uses the rest of the PA/SMVA to document the need for the requested services.

1. Complete Elements A and B.
2. Read the PA statement before signing the PA/SMVA.
3. Sign and date the PA/SMVA.

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 11
Sample Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA)

Mail To:
EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SMVA

Prior Authorization Specialized Medical Vehicle Attachment

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

Recipient Information

① Last Name	② First Name	③ Middle Initial	④ Medicaid ID Number	⑤ Age
Recipient	Ima	A	9876543210	25

Provider Information

⑥ Performing Provider's Name	⑦ Performing Provider's Medicaid Provider Number	⑧ Performing Provider's Telephone Number
I. M. Provider	12345678	(555) 555 - 5555

A. Do you have a current Physician Certification, signed by a physician, physician assistant, nurse midwife, or nurse practitioner documenting the recipient's need for SMV transportation on file for this recipient?

☐ Yes ☐ No

B. Please attach a copy of the prescription for trips that exceed the SMV mileage limit signed and dated by a physician, physician assistant, nurse midwife, nurse practitioner, dentist, optometrist/optician, chiropractor, podiatrist, HealthCheck agency, or family planning clinic.

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

C. MM/DD/YYYY (Date) — I. M. Provider (Requesting Provider's Signature)

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 12
Prior Authorization Specialized Medical Vehicle Attachment (PA/SMVA) (for photocopying)

(A copy of the Prior Authorization Specialized Medical Vehicle Attachment [PA/SMVA] is located on the following page.)

Mail To:
EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SMVA

Prior Authorization Specialized Medical Vehicle Attachment

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

Recipient Information

① Last Name	② First Name	③ Middle Initial	④ Medicaid ID Number	⑤ Age

Provider Information

⑥ Performing Provider's Name	⑦ Performing Provider's Medicaid Provider Number	⑧ Performing Provider's Telephone Number
		( ) -

A. Do you have a current Physician Certification, signed by a physician, physician assistant, nurse midwife, or nurse practitioner documenting the recipient's need for SMV transportation on file for this recipient?

❑ Yes ❑ No

B. Please attach a copy of the prescription for trips that exceed the SMV mileage limit signed and dated by a physician, physician assistant, nurse midwife, nurse practitioner, dentist, optometrist/optician, chiropractor, podiatrist, HealthCheck agency, or family planning clinic.

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

C. _____ _____

Date Requesting Provider's Signature

Appendix 13
Wisconsin Medicaid STAT-PA Instructions

The Wisconsin Medicaid Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system is an electronic PA system that allows Medicaid-certified providers to request and receive PA electronically rather than by mail or fax. Providers answer a series of questions and receive an immediate response of an approved or returned PA.

Providers communicate with the STAT-PA system by entering requested information on a personal computer, a touch-tone telephone keypad, or by calling a STAT-PA help desk correspondent. The automated system is available from 8:00 a.m. to 11:45 p.m., seven days a week. The STAT-PA help desk is available from 8:00 a.m. to 6:00 p.m., Monday through Friday, excluding holidays.

Required Information

All providers using STAT-PA will be required to provide the following information:

- Eight-digit Medicaid provider number.
- Recipient's 10-digit Medicaid identification number.
- Procedure code of product requested.
- Type of service (TOS) code.
- *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code.
- Place of service (POS) code.
- Requested grant date or date of service.
- Quantity or days' supply.

Refer to Appendix 14 of this handbook for an optional worksheet for documenting the information needed to request PA for specialized medical vehicle transportation.

How to Use Wisconsin Medicaid STAT-PA

To use STAT-PA:

1. Complete the Wisconsin Medicaid Specialized Medical Vehicle STAT-PA Worksheet.
2. Select the mode of transmission (personal computer, touch-tone telephone, or help desk).

Personal Computer Requests

To use a personal computer to submit a PA request:

1. Providers enter the PA information into the STAT-PA software provided by Wisconsin Medicaid. To access the STAT-PA software and user manual from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/,* providers should:
   - Select "Providers" from the Medicaid main menu at the top of the page.
   - Scroll down to the "Reference/Tools" topic section and select "STAT-PA software."
   - Follow the steps indicated to ensure proper installation of the STAT-PA software.
   - The software and user manual may also be obtained electronically through Wisconsin Medicaid's Bulletin Board System, EDS-EPIX (Searchlight). Providers who are unable to access the Bulletin Board through their personal computer may request software by calling the STAT-PA help desk at (800) 947-1197 or (608) 221-2096.
2. Once all data have been entered, the provider transmits the electronic request by using a modem and telephone line. The telephone number is (800) 947-4947 or (608) 221-1233. Refer to the STAT-PA user manual for more information on how to transmit the electronic request.

STAT-PA processes the information and, in minutes, generates an electronic confirmation transaction that displays directly on the provider's personal computer screen. The transaction shows:

- What the provider requested.
- The authorized procedure code.
- The assigned PA number.
- Grant and expiration dates.

Telephone Requests

To use a touch-tone telephone to submit a PA request:

1. Call (800) 947-1197 or (608) 221-2096 to connect directly with the STAT-PA system.
2. When the system answers, it will ask a series of questions that providers answer by entering the information on the telephone keypad. The Wisconsin Medicaid Specialized Medical Vehicle STAT-PA Worksheet (Appendix 14 of this handbook) gives the information needed in the order it is requested.

Note: When using a touch-tone telephone to enter the Medicaid provider number, recipient identification number, procedure code, TOS code, ICD-9-CM diagnosis code, POS code, requested grant date, and quantity, always press the pound (#) sign to mark the end of the data just entered. The pound (#) sign signals to the system that the provider has finished entering the data requested and ensures the quickest response from the system.

Providers may be asked to enter alphabetic data, which can be entered by using the asterisk (*) key. For example, a provider is asked to enter a procedure code, such as L3216. The first character is an alpha character; therefore, the provider presses the single asterisk (*) followed by the two digits that indicate the letter. The first digit is the number on the keypad where the letter is located, and the second digit is the position of the letter on that key. For example: Procedure code L3216 should be entered as *53 3 2 1 6.

Alphabet Key				
A = *21	G = *41	M = *61	S = *73	Y = *93
B = *22	H = *42	N = *62	T = *81	Z = *12
C = *23	I = *43	O = *63	U = *82	
D = *31	J = *51	P = *71	V = * 83	
E = *32	K = *52	Q = *11	W = *91	
F = *33	L = *53	R = *72	X = *92	

3. Once all data have been entered completely, STAT-PA begins to process the information and, in minutes, indicates the PA number and, if approved, the authorized level of service.

Once familiar with the STAT-PA system, providers may enter the PA information in the designated order immediately — there is no need to wait for the full voice prompt. Providers may key information at any time, even when the system is relaying information. The system automatically proceeds to the next function.

STAT-PA Help Desk Requests

Providers who do not have a personal computer or touch-tone telephone may call the STAT-PA help desk. The help desk correspondent has the personal computer software to access STAT-PA and enters the required data requested from the provider. For the help desk, call (800) 947-1197 or (608) 221-2096.

The STAT-PA help desk is available to all providers using STAT-PA. Providers may use the help desk to order software for a personal computer or to report difficulties with the system.

Documentation Information

All providers using STAT-PA must maintain documentation information consistent with the following:

- Providers are required to retain the assigned PA number for:
  - √ Use in claims submission, if approved.
  - √ Submission of a paper PA request when more clinical documentation is needed.
- Providers also receive a confirmation notice by mail indicating the assigned PA number and the STAT-PA decision. This confirmation notice should be maintained as a permanent record of the transaction.
- Providers must maintain all documentation that supports medical necessity, claim information, and delivery of equipment in their records for a period not less than five years.

Helpful Hints

The following tips may help in using the STAT-PA system:

- In personal computer transactions, the provider is given 40 seconds to respond to requested data for each field of information. If the provider is making changes to a field, the provider is then given 90 seconds to respond before being disconnected. If disconnected, the provider may try again.
- In touch-tone telephone transactions, the provider is given three attempts at each field to correctly enter the requested data. Failure to enter any data within three minutes ends the telephone connection.
- Providers are allowed 25 PA requests per connection for personal computers and five PA requests per connection for touch-tone telephone and help desk.
- The decimal point for diagnosis codes is not required when entering a STAT-PA request by personal computer or touch-tone telephone; however, all digits of the codes must be entered.
- The grant date entered by the provider may be up to 31 calendar days in the future.
- In the event that the STAT-PA system is unavailable at the time the service is provided, the PA request may be backdated up to four calendar days.
- Providers needing to end-date a PA request due to a change in prescription may do so through the STAT-PA help desk. The help desk correspondent will assist the provider through this process.
- The help desk is available to all STAT-PA users. If difficulties with the system arise, please call the help desk.

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Appendix 14
Wisconsin Medicaid Specialized Medical Vehicle STAT-PA Worksheet (for photocopying)

(A copy of the Wisconsin Medicaid Specialized Medical Vehicle STAT-PA Worksheet is located on the following page.)

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE STAT-PA WORKSHEET

The specialized medical vehicle (SMV) Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) Worksheet is not a required worksheet for documenting the information needed to request PA for SMV transportation. Providers may find it helpful to enter the information requested in each category in the spaces provided to the right of each item before connecting to the STAT-PA system.

Name — Recipient	
Prior Authorization (PA) Number The STAT-PA system will indicate the seven-digit PA number at the end of the transaction. Please record the number here.	

STAT-PA REQUEST CHECKLIST

The STAT-PA system will ask for the following items in the order listed below.

Wisconsin Medicaid Provider Number Enter the provider's eight-digit Medicaid provider number.	
Recipient Medicaid Identification Number Enter the recipient's ten-digit Medicaid identification number. This can be found on the recipient's Medicaid identification card.	
Procedure Code of Product Requested	**00025**
Type of Service (TOS) Code	**9**
Diagnosis Code	**00025**
Place of Service (POS) Code Enter the POS code for this trip. Refer to Appendix 32 of this handbook for a list of allowed POS codes.	
Requested Grant Date or Date of Service Enter the date in the eight-digit MMDDYYYY format. The grant date entered may be up to 31 calendar days in the future. In the event that the STAT-PA system is unavailable at the time the service is provided, the PA request may be backdated up to four calendar days.	
Quantity or Days' Supply Requested	
Service Provided Modifier Refer to Appendix 33 of this handbook for a list of allowable modifiers.	
Certification of Need for Specialized Medical Vehicle Transportation on File?	☐ **YES** ☐ **NO**
Prescription Date Enter the eight-digit signature date on the prescription in MMDDYYYY format. The prescription date cannot be more than six months in the past from the requested grant date.	

REMINDER: A PA number will be assigned at the end of the transaction. Please enter the assigned PA number in the space provided at the top of this worksheet below the recipient's name.

Appendix 15
Prior Authorization by Fax Guidelines

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

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

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

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

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

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

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

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

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

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

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

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

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Appendix 16
CMS 1500 Claim Form Completion Instructions

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

Note: Medicaid providers should ***always*** verify recipient eligibility before providing services.

Element 1 — Program Block / Claim Sort Indicator
Enter claim sort indicator "A" 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.

Element 2 — Patient's Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., September 25, 1975, would be 09/25/75) or in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975). Specify if 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.

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 (not required)

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

Element 11 — Insured's Policy, Group, or FECA Number (not required)

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)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source
Wisconsin Medicaid requires this element to be completed for all specialized medical vehicle (SMV) services, except when the transportation is the result of a nursing home or hospital discharge. Enter the name of the referring/prescribing physician, physician assistant, nurse midwife, or nurse practitioner. The referring provider is the medical practitioner who signed the Certification of Need for Specialized Medical Vehicle Transportation form documenting the recipient's need for SMV transportation.

Nursing Home or Hospital Discharge

Specialized medical vehicle claims for transportation of a recipient due to a nursing home or hospital discharge do not require a referring physician's Universal Provider Identification Number or Medicaid provider number. Element 17 is left blank in this situation.

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code V63.0.

If the SMV one-way trip is over 40 miles, enter the county code showing where the trip began in the first line of the first diagnosis field. (Enter *ICD-9-CM* diagnosis code V63.0 in the second diagnosis field.) Refer to Appendix 34 of this handbook for a list of county codes.

Nursing Home or Hospital Discharge

Specialized medical vehicle claims for transportation of a recipient due to a nursing home or hospital discharge also require description code G11.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers.

Element 24A — Date(s) of Service

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

- When billing for one date of service (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 subsequent DOS in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

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 procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.

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

Element 24B — Place of Service
Enter the appropriate Medicaid single-digit POS code for each service. Refer to Appendix 32 of this handbook for allowable POS codes and descriptions.

Element 24C — Type of Service
Enter Medicaid TOS code "9" for each service. Refer to Appendix 32 of this handbook for the TOS code description.

Element 24D — Procedures, Services, or Supplies
Enter the appropriate local procedure code. Refer to Appendix 32 of this handbook for a list of allowable procedure codes and their descriptions.

Modifiers

Enter the appropriate two-character modifier in the "Modifier" column of Element 24D. Refer to Appendix 33 of this handbook for a list of the allowable modifier codes. Please note that Wisconsin Medicaid has ***not*** adopted all *Current Procedural Terminology*, Healthcare Common Procedure Coding System, or Medicare modifiers.
All SMV procedure codes require two modifiers:

1. Number of trip modifiers: Use modifier codes "11" through "20" to indicate the number of trips for the same recipient, by the same provider, on the same DOS.
2. Service-provided modifiers: Wisconsin Medicaid requires a second modifier to indicate the type of medical service provided at the destination. Providers will only receive reimbursement for trips to Medicaid-covered medical services.

Element 24E — Diagnosis Code
Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code(s) listed in Element 21. If a county code is entered in Element 21, enter the reference that shows the county code's position in this element.

Element 24F — Charges
Enter the total charge for each line item.

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., 2.3 units).

Element 24H — EPSDT/Family Planning (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use
Any information entered in this element may cause claim denial.

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

Element 26 — Patient's Account No. (optional)
The provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge
Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

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.

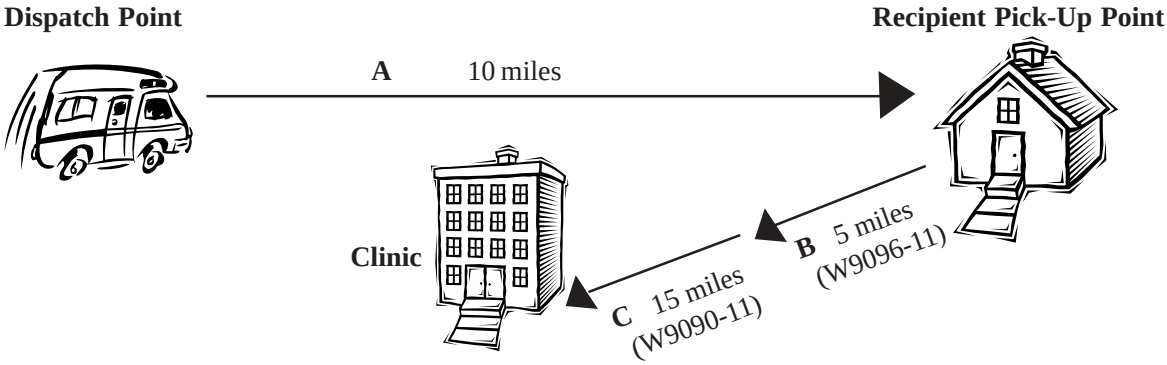
Element 32 — Name and Address of Facility Where Services Were Rendered
If services are provided to a recipient who resides in a nursing home (POS code "7" or "8"), indicate the nursing home's eight-digit Medicaid provider number.

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 17
Illustration of Two Trips with Waiting Time

The following is an example of a trip that includes waiting time. "Waiting time" refers to time spent by the specialized medical vehicle (SMV) provider waiting for the recipient to return to the vehicle while the recipient receives medical services.

TRIP ONE WITH WAITING TIME



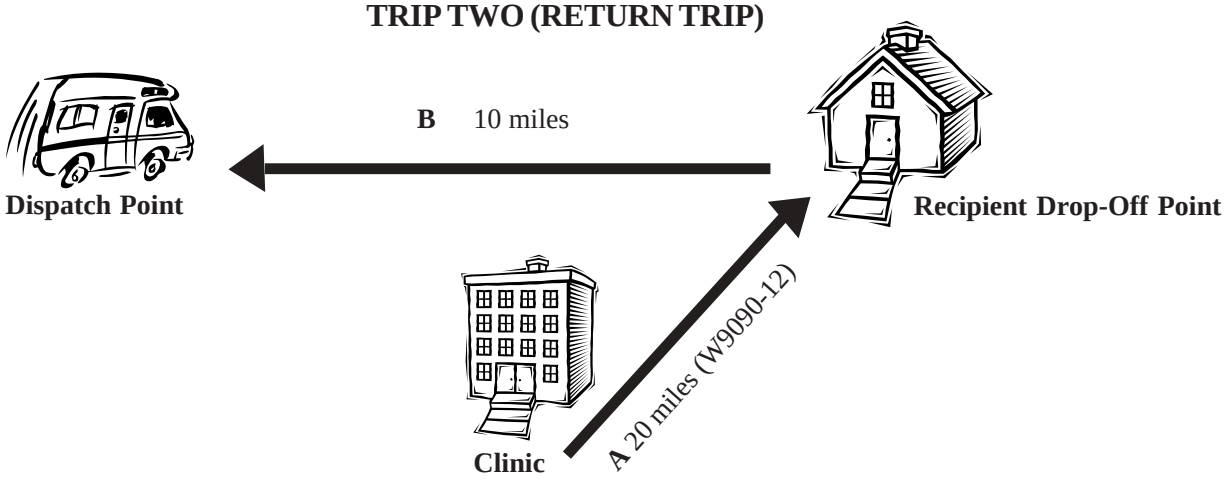
A Van travels to recipient pick-up point — no unloaded mileage because distance is 10 miles. Wisconsin Medicaid reimburses for unloaded mileage when the SMV travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Base rate (W9096-11) includes first five miles.

C Remaining 15 miles to clinic count as mileage (W9090-11).

D Van waits for recipient at clinic for two hours — counts as waiting time (W9095-11).

TRIP TWO (RETURN TRIP)



A Van transports recipient to home (drop-off point) — base rate not billable because waiting time is billed. Billed as mileage (W9090-12).

B Van returns to dispatch point empty. Unloaded mileage not allowed.

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Appendix 18
Sample CMS 1500 Claim Form: Two Trips with Waiting Time

This claim form illustrates a sample form for the example in Appendix 17 of this handbook.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID [A] (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

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 M ☐ F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

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) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ 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? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

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 MM DD YY FROM ____ TO ____

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I. M. Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM ____ TO ____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V63.0 3. ____ 2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	9	W9096	11 TD	1,2	XXX XX	1				
2 MM DD YY		3	9	W9090	11 TD	1,2	XXX XX	15				
3 MM DD YY		3	9	W9095	11 TD	1,2	XXX XX	2				
4 MM DD YY		4	9	W9090	12 TD	1,2	XXX XX	20				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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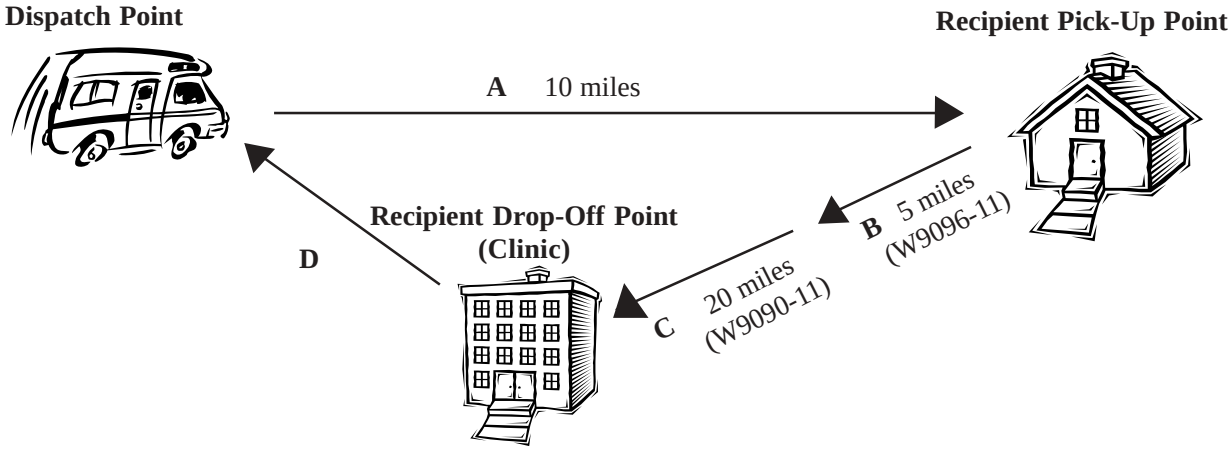
Appendix 19
Illustration of Two Trips with Second Attendant

The following is an example of two trips made with a second attendant.

TRIP ONE



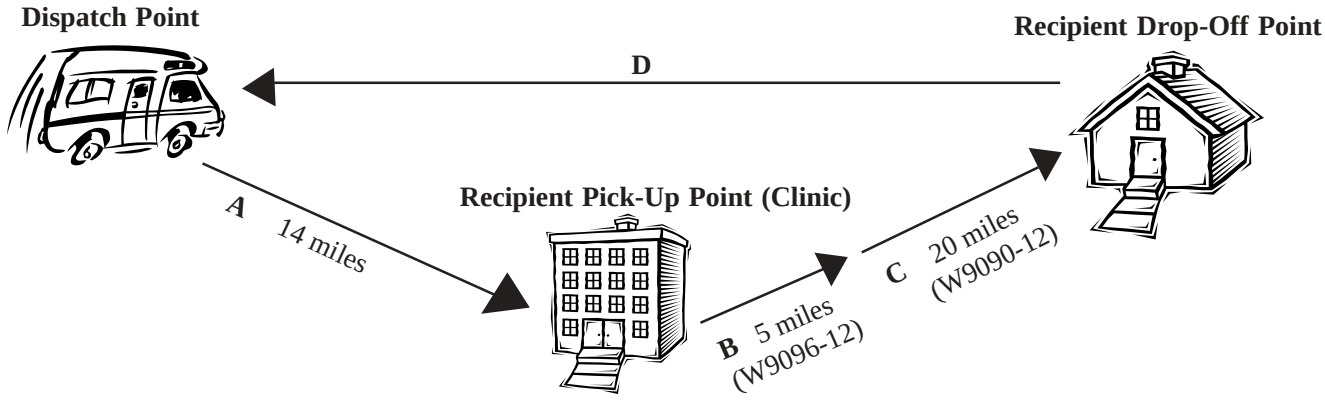
A Travel to recipient pick-up point — no unloaded mileage because distance is 10 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Travel from pick-up point to drop-off point — base rate (W9096-11) includes the first five miles of 25-mile distance. Recipient requires cot/stretcher transportation and second attendant (W9098-11).

C Travel from pick-up point to drop-off point — the remaining 20 miles of the 25-mile distance to clinic count as mileage (W9090-11).

D Recipient stays at clinic — van returns empty to dispatch point. Unloaded mileage not allowed.

TRIP TWO



A Van returns to clinic to pick up recipient — no unloaded mileage because distance is under 20.1 miles.

B Recipient picked up and transported to drop-off point — base rate (W9096-12) includes the first five miles of 25-mile distance. Recipient requires cot/stretcher transportation and second attendant (W9098-12).

C The remaining 20 miles of 25-mile distance to recipient's home count as mileage (W9090-12).

D Van returns empty to dispatch point from recipient's drop-off point. Unloaded mileage not allowed.

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Refer to the Online Handbook
for current policy

Appendix 20
Sample CMS 1500 Claim Form: Two Trips with Second Attendant

This claim form illustrates a sample form for the example in Appendix 19 of this handbook.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — [A] (Medicaid #)

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: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] | Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

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) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V63.0 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	9	W9096	11 TM	1	XXX XX	1				
2 MM DD YY		3	9	W9090	11 TM	1	XXX XX	20				
3 MM DD YY		3	9	W9098	11 TM	1	XXX XX	1				
4 MM DD YY		4	9	W9096	12 TM	1	XXX XX	1				
5 MM DD YY		4	9	W9090	12 TM	1	XXX XX	20				
6 MM DD YY		4	9	W9098	12 TM	1	XXX XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 00 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 5555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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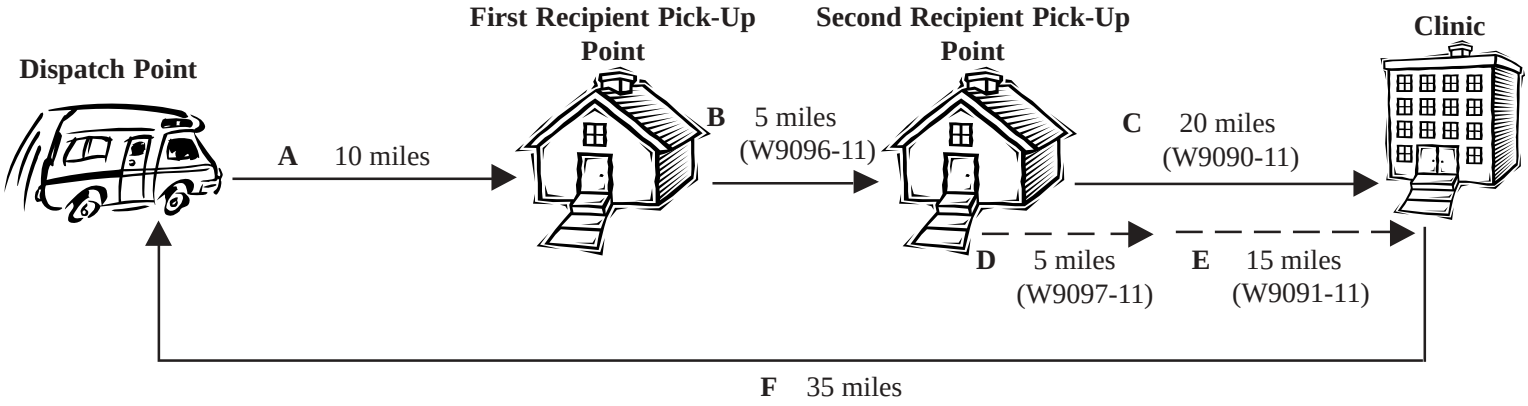
Appendix 21
Illustration of One Trip with Multiple Recipients (Multiple Carry)

The following is an example of one trip made with multiple recipients.



First Recipient's Trip

A Travel to first recipient's pick-up point — no unloaded mileage because distance is 10 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Travel to second recipient's pick-up point — the first five miles of 25-mile distance to clinic for first recipient's trip are billed at the base rate (W9096-11). Unloaded mileage is not allowed because the vehicle has a passenger.

C Vehicle picks up second recipient and transports both recipients to clinic — the remaining 20 miles count as mileage (W9090-11).

F Both recipients stay at clinic — van returns empty to dispatch point. Unloaded mileage not allowed.

Second Recipient's Trip

D Vehicle picks up second recipient and travels from second recipient's pick-up point to clinic — the first five miles of the 20-mile distance for second recipient's trip to the clinic are billed at the multiple carry base rate (W9097-11).

E The remaining 15 miles of the 20-mile distance for second recipient's trip to the clinic are billed as multiple carry mileage (W9091-11).

F Both recipients stay at clinic — van returns empty to dispatch point. Unloaded mileage not allowed.

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Refer to the Online Handbook
for current policy

Appendix 22
Sample CMS 1500 Claim Form: First Recipient on Multiple Carry Trip

This claim form illustrates a sample form for the example in Appendix 21 of this handbook.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [A] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

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 M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

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) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V63.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		4	9	W9096	11 TM	1	XXX XX	1				
2 MM DD YY		4	9	W9090	11 TM	1	XXX XX	20				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 00 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 5555

PIN# GRP# 87654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Appendix

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Appendix 23
Sample CMS 1500 Claim Form: Second Recipient on Multiple Carry Trip

This claim form illustrates a sample form for the example in Appendix 21 of this handbook.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) A | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0987654321

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 M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

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) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | 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? YES | NO *If yes,* return to and complete item 9 a-d.

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 _____

PATIENT AND INSURED INFORMATION

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V63.0 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	9	W9097	11 TM	1	XXX XX	1				
2 MM DD YY		3	9	W9091	11 TM	1	XXX XX	15				
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 00 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 5555

PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

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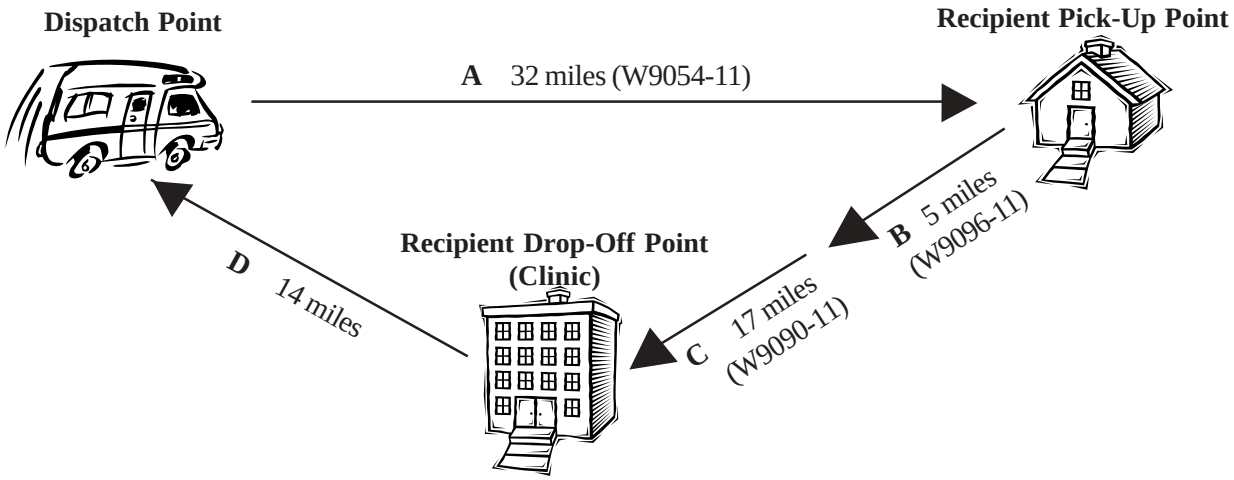
Appendix 24
Illustration of Two Trips with Unloaded Mileage

The following is an example of two trips including unloaded mileage. "Unloaded mileage" is the distance traveled to pick up the recipient for transport to or from Medicaid-covered services.

TRIP ONE



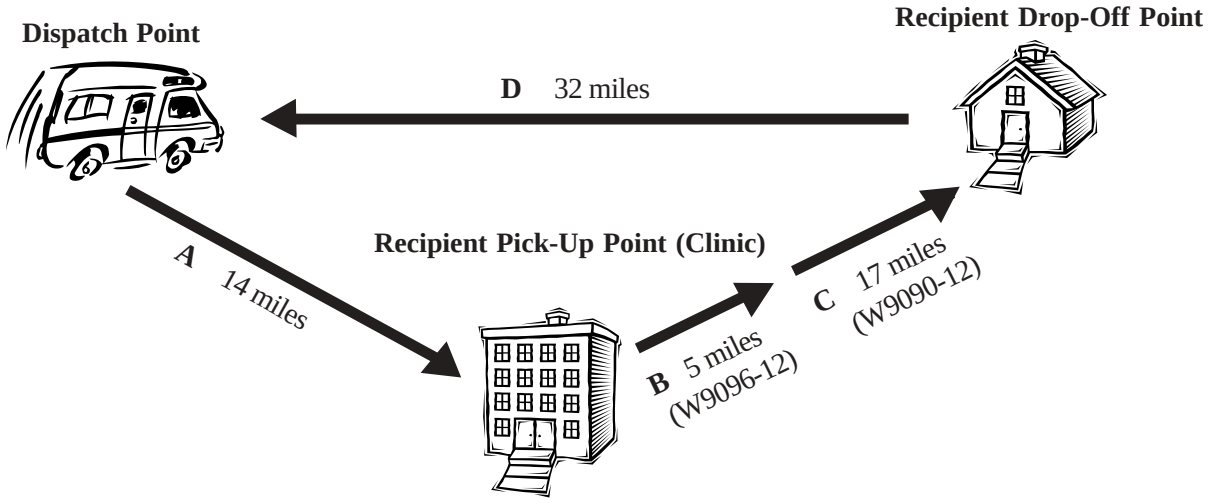
A Van travels to recipient's home to pick up recipient — unloaded mileage (W9054-11) applies because the trip is 32 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Van picks up recipient and travels to clinic; the first five miles are the base rate (W9096-11).

C Remaining 17 miles to clinic count as mileage (W9090-11).

D Van returns to base empty. Unloaded mileage not allowed.

TRIP TWO



A Van returns to clinic to pick up recipient. No unloaded mileage because distance is 14 miles.

B Van picks up recipient and travels to recipient's home. The first five miles traveled are the base rate (W9096-12).

C The remaining 17 miles to recipient's home count as mileage (W9090-12).

D Van returns to base empty. Unloaded mileage not allowed.

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Appendix 25
Sample CMS 1500 Claim Form: Two Trips with Unloaded Mileage

This claim form illustrates a sample form for the example in Appendix 24 of this handbook.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) A | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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 M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES 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? YES NO *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V63.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	3	9	W9054	11 TH	1	XXX XX	1				
2 MM DD YY	3	9	W9096	11 TH	1	XXX XX	1				
3 MM DD YY	3	9	W9090	11 TH	1	XXX XX	17				
4 MM DD YY	4	9	W9096	12 TH	1	XXX XX	1				
5 MM DD YY	4	9	W9090	12 TH	1	XXX XX	17				
6											

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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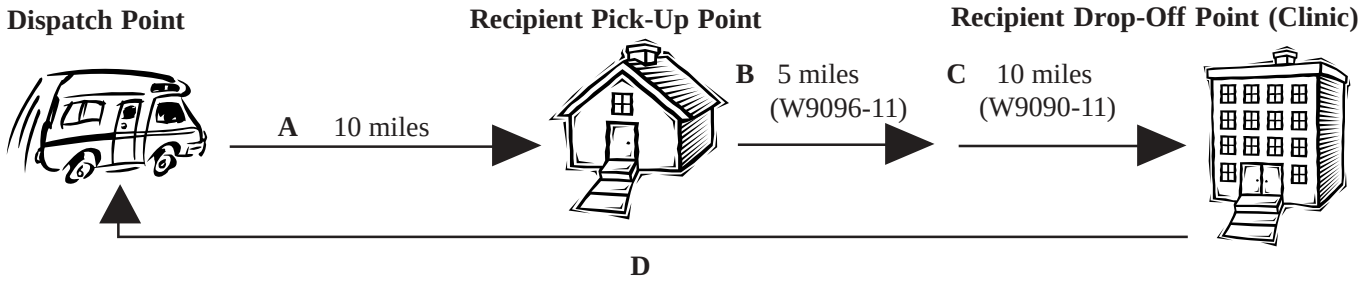
Appendix 26
Illustration of Three Trips for a Single Recipient on One Day

The following is an example of three trips including unloaded mileage.

TRIP ONE



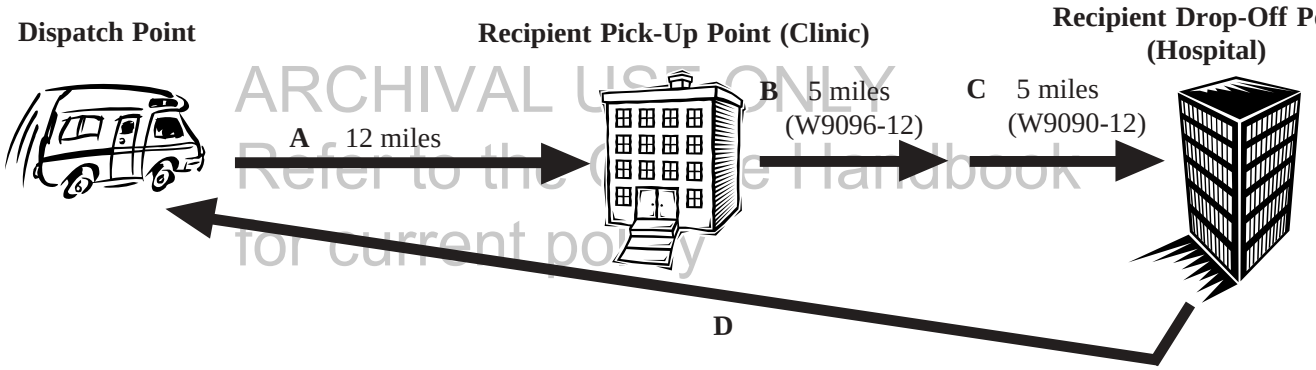
A Van travels to recipient's home to pick up recipient — no unloaded mileage because distance is 10 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Van transports recipient from home to clinic — the base rate (W9096-11) includes the first five miles of the trip.

C The remaining 10 miles to the clinic count as mileage (W9090-11).

D Recipient stays at clinic — van returns to base empty. Unloaded mileage not allowed.

TRIP TWO



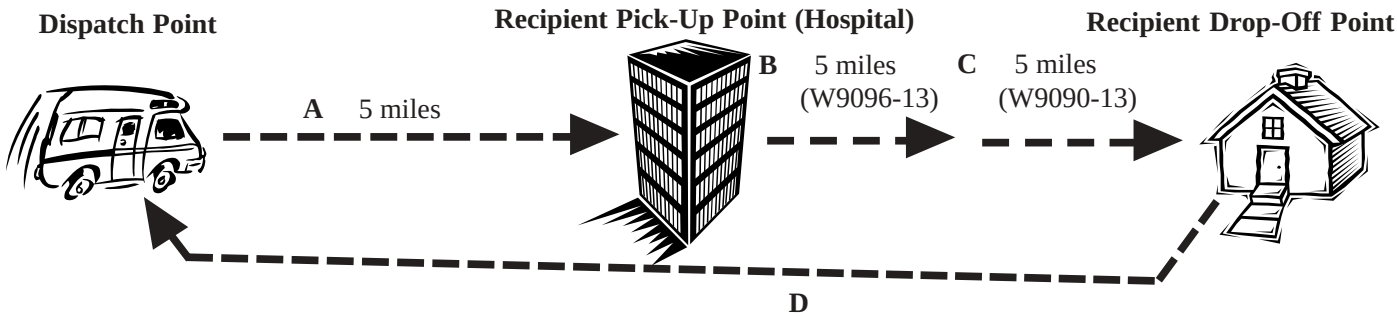
A Van returns to clinic to pick up recipient — no unloaded mileage because distance is 12 miles.

B Recipient picked up — base rate (W9096-12) includes the first five miles to hospital.

C The remaining five miles to hospital count as mileage (W9090-12).

D Recipient stays at hospital — van returns to dispatch point empty. Unloaded mileage not allowed.

TRIP THREE



A Van returns to hospital to pick up recipient — no unloaded mileage because distance is 5 miles.

B Van transports recipient home from hospital — Base rate (W9096-13) includes first five miles of the trip.

C The remaining five miles to the recipient's home count as mileage (W9090-13).

D Van returns to dispatch point empty. Unloaded mileage not allowed.

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Appendix 27

Sample CMS 1500 Claim Form: Three Trips for a Single Recipient on One Day

This claim form illustrates a sample form for the example in Appendix 26 of this handbook.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) A | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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 M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

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) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | 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? YES | NO *If yes,* return to and complete item 9 a-d.

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

PATIENT AND INSURED INFORMATION

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V63.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	9	W9096	11 TL	1	XX XX	1				
2 MM DD YY		3	9	W9090	11 TL	1	XX XX	10				
3 MM DD YY		2	9	W9096	12 TS	1	XX XX	1				
4 MM DD YY		2	9	W9090	12 TS	1	XX XX	5				
5 MM DD YY		4	9	W9096	13 TL	1	XX XX	1				
6 MM DD YY		4	9	W9090	13 TL	1	XX XX	5				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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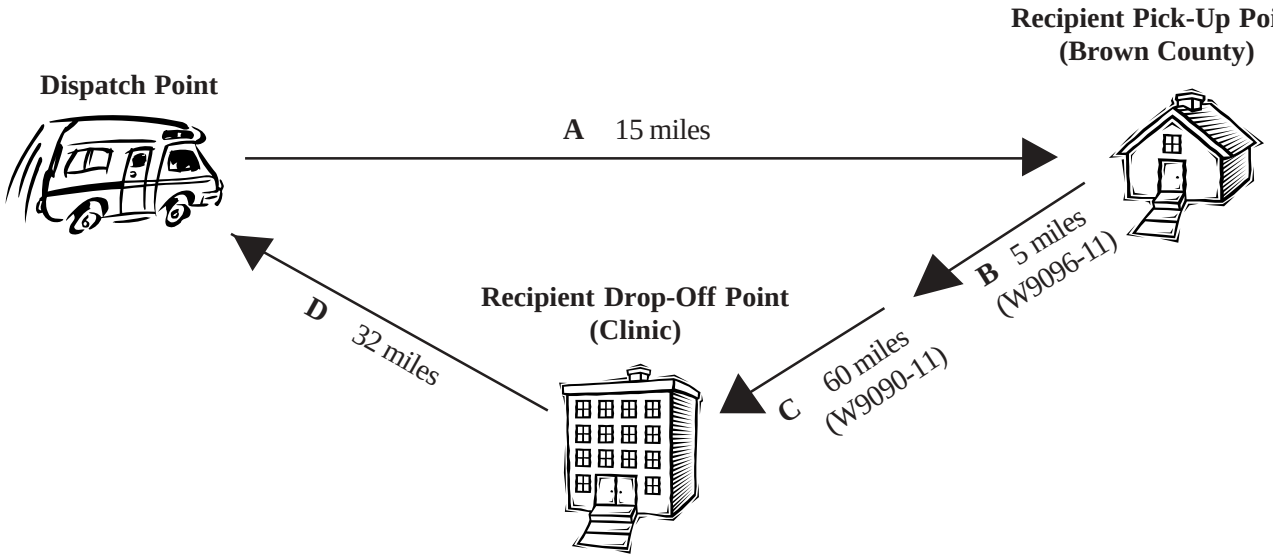
Appendix 28
Illustration of One Trip with Extended Travel (Over 40 Miles)

The following is an example of one trip with travel over 40 miles.



A Van travels to recipient's home to pick up recipient — no unloaded mileage because distance is 15 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Van transports recipient from home to clinic — the base rate (W9096-11) includes the first five miles of the trip.

C The remaining 60 miles to the clinic count as mileage (W9090-11). Because the trip is over 40 miles and begins in Brown County, the SMV provider is required to have prior authorization (PA) for the trip. Refer to the Prior Authorization chapter of this handbook for information on other trips that may require PA.

D Recipient stays at clinic — van returns to base empty. Unloaded mileage not allowed.

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Appendix 29
Sample CMS 1500 Claim Form: One Trip with Extended Travel (Over 40 miles)

This claim form illustrates a sample form for the example in Appendix 28 of this handbook.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

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 M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - D

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) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ 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? YES ☐ NO ☐ *If yes,* return to and complete item 9 a-d.

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. T005
2. V63.0
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	9	W9096	11 TM	1	XXX XX	1				
2 MM DD YY		3	9	W9090	11 TM	1	XXX XX	60				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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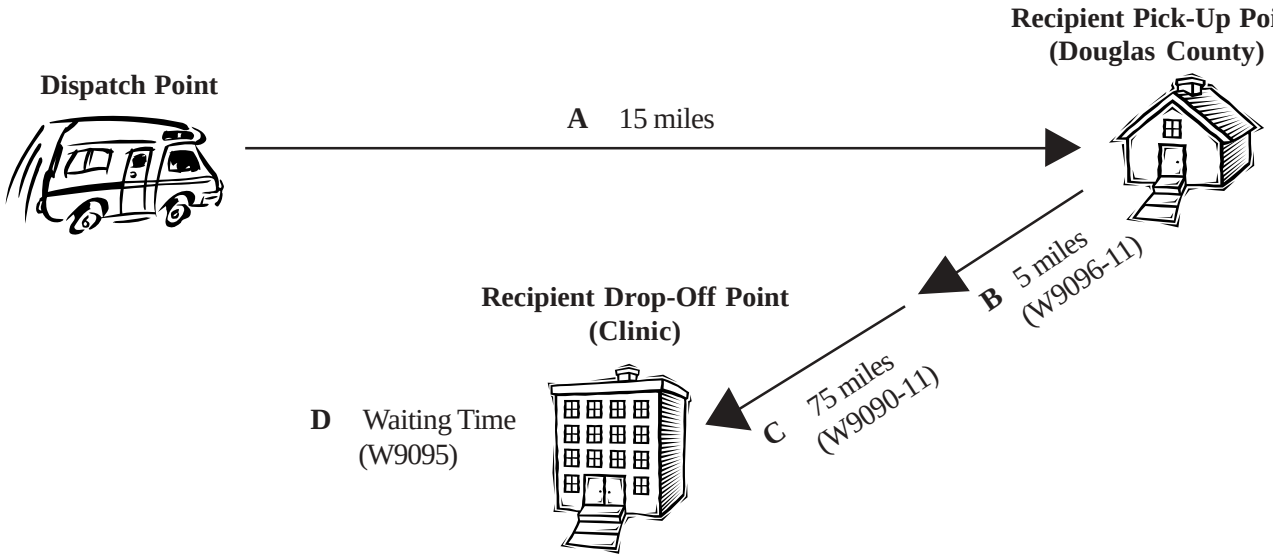
Appendix 30
Illustration of Two Trips with Extended Travel (Over 70 Miles)

The following is an example of two trips with travel over 70 miles.

TRIP ONE



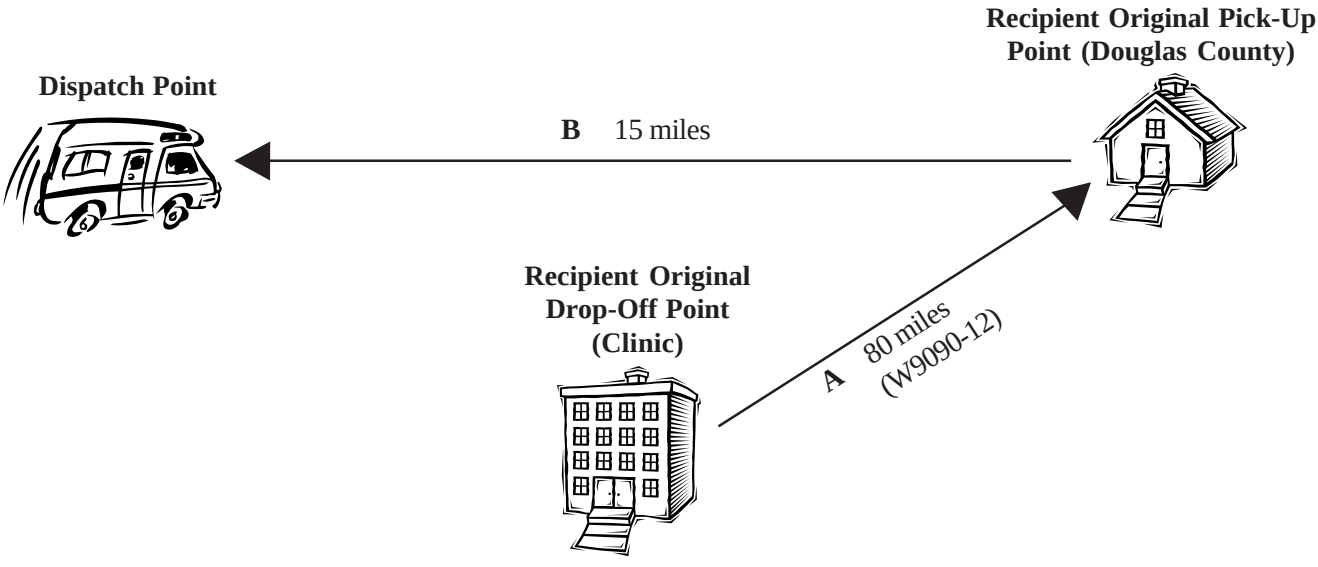
A Van travels to recipient's home to pick up recipient — no unloaded mileage because distance is 15 miles. Wisconsin Medicaid reimburses for unloaded mileage when the specialized medical vehicle (SMV) travels empty more than 20 miles by the shortest route available from the dispatch point (i.e., SMV starting location) to the recipient's location.

B Van transports recipient from home to clinic — the base rate (W9096-11) includes the first five miles of the trip.

C The remaining 75 miles to the clinic count as mileage (W9090-11). Because the trip is over 70 miles and begins in Douglas County, the SMV provider is required to have prior authorization (PA) for the trip. Refer to the Prior Authorization chapter of this handbook for information on other trips that may require PA.

D Van waits at clinic for recipient for one hour — counts as waiting time (W9095).

TRIP TWO



A Van transports recipient from clinic to home (W9090-12).

B Van returns empty to dispatch point — unloaded mileage not allowed.

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Appendix 31
Sample CMS 1500 Claim Form: Two Trips with Extended Travel (Over 70 Miles)

This claim form illustrates a sample form for the example in Appendix 30 of this handbook.

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — [A] MEDICAID

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 M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: — STATE:

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

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) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

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 MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. T016 . 3. _____ .

2. V63.0 . 4. _____ .

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		3	9	W9096	11 TD	1	XXX XX	1				
2 MM DD YY		3	9	W9090	11 TD	1	XXX XX	75				
3 MM DD YY		3	9	W9095	11 TD	1	XXX XX	1				
4 MM DD YY		4	9	W9090	12 TD	1	XXX XX	80				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix

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Appendix 32
Local Procedure Codes, Place of Service Codes, and Type of Service Code for Specialized Medical Vehicle Services

Wisconsin Medicaid requires local procedure codes for all specialized medical vehicle (SMV) claims. Refer to the following table to determine the usage of the appropriate code and the corresponding allowable place of service (POS) codes. The POS codes describe the SMV's destination.

HCPCS* Procedure Codes and POS Codes for SMV Services		
Procedure Codes	**Description**	**Allowable POS Codes**
W9053	SMV unloaded mileage (20.1 to 30 miles)	0, 1, 2, 3, 4, 7, 8, B
W9054	SMV unloaded mileage (30.1 to 45 miles)	0, 1, 2, 3, 4, 7, 8, B
W9055	SMV unloaded mileage (45.1 to 60 miles)	0, 1, 2, 3, 4, 7, 8, B
W9056	SMV unloaded mileage (60.1 to 75 miles)	0, 1, 2, 3, 4, 7, 8, B
W9057	SMV unloaded mileage (75.1 to 90 miles)	0, 1, 2, 3, 4, 7, 8, B
W9058	SMV unloaded mileage (90.1 miles and greater)	0, 1, 2, 3, 4, 7, 8, B
W9090**	SMV mileage (actual miles beyond first five miles of trip)	0, 1, 2, 3, 4, 7, 8, B
W9091**	Multiple carry SMV mileage (beyond first five miles of trip)	0, 1, 2, 3, 4, 7, 8, B
W9095	SMV waiting time, per hour	0, 2, 3, 7, 8, B
W9096	SMV base rate (includes first five miles; always quantity of one)	0, 1, 2, 3, 4, 7, 8, B
W9097	Multiple carry SMV base rate (includes first five miles; always quantity of one)	0, 1, 2, 3, 4, 7, 8, B
W9098	SMV second attendant (per trip)	0, 1, 2, 3, 4, 7, 8, B

* Healthcare Common Procedure Coding System.

** Requires prior authorization for trips over 40 miles in the counties listed in the Prior Authorization chapter of this handbook or over 70 miles in all other Wisconsin counties.

Medicaid-Allowable POS Codes	
POS Code	**Description**
0	Other
1	Inpatient hospital
2	Outpatient hospital
3	Office
4	Home
7	Nursing home
8	Skilled nursing facility
B	Ambulatory surgical center

Indicate type of service (TOS) code "9" with each procedure code listed on the claim.

Medicaid-Allowable TOS Code	
TOS Code	**Description**
9	Other

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Appendix 33
Allowable Modifiers and Description Code for Specialized Medical Vehicle Services

Wisconsin Medicaid requires one trip modifier and one service-provided modifier in Element 24 of the CMS 1500 claim form. Use the trip modifier codes "11" through "20" to indicate the number of trips for the same recipient, by the same provider, on the same date of service.

Trip Modifiers (required in Element 24D of the CMS 1500 claim form)				
Modifier	**Description**		**Modifier**	**Description**
11	First or only trip		16	Sixth trip
12	Second trip		17	Seventh trip
13	Third trip		18	Eighth trip
14	Fourth trip		19	Ninth trip
15	Fifth trip		20	Tenth trip

Use the service-provided modifiers to indicate the Medicaid-covered medical service to which the recipient is being transported.

Service-Provided Modifiers (required in Element 24D of the CMS 1500 claim form)							
Modifier	**Definition**		**Modifier**	**Definition**		**Modifier**	**Definition**
TB	Chiropractor		TH	Therapy (includes physical therapy, occupational therapy, speech therapy, and audiology)		TO	Methadone clinic
TC	Case management, prenatal care coordination		TI	Dialysis		TR	Rehabilitation agency
TD	Dental		TL	Mental health, community support program		TS	Hospital services
TE	Medical equipment supplier/ hearing instrument specialist		TM	Medical services by a physician, nurse practitioner, physician assistant, nurse midwife or family planning clinic, HealthCheck, rural health, podiatry, vision, or ambulatory surgery center			

Use the description code below to indicate hospital or nursing home discharge. Providers must indicate the diagnosis code V63.0 in Element 21 of the CMS 1500 claim form.

Description Code	
Code	**Description**
G11	Hospital/nursing home discharge (refer to Claims Submission chapter of this handbook for more information on submitting claims for hospital and nursing home discharges)

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Appendix 34
County Codes

Use the following county codes to identify on the CMS 1500 claim form the point of origin for specialized medical vehicle trips with extended travel.

County Codes for Point of Origin		
T001 — Adams	T025 — Iowa	T049 — Portage
T002 — Ashland	T026 — Iron	T050 — Price
T003 — Barron	T027 — Jackson	T051 — Racine
T004 — Bayfield	T028 — Jefferson	T052 — Richland
T005 — Brown	T029 — Juneau	T053 — Rock
T006 — Buffalo	T030 — Kenosha	T054 — Rusk
T007 — Burnett	T031 — Kewaunee	T055 — St. Croix
T008 — Calumet	T032 — LaCrosse	T056 — Sauk
T009 — Chippewa	T033 — LaFayette	T057 — Sawyer
T010 — Clark	T034 — Langlade	T058 — Shawno
T011 — Columbia	T035 — Lincoln	T059 — Sheboygan
T012 — Crawford	T036 — Manitowoc	T060 — Taylor
T013 — Dane	T037 — Marathon	T061 — Trempealeau
T014 — Dodge	T038 — Marinette	T062 — Vernon
T015 — Door	T039 — Marquette	T063 — Vilas
T016 — Douglas	T040 — Milwaukee	T064 — Walworth
T017 — Dunn	T041 — Monroe	T065 — Washburn
T018 — Eau Claire	T042 — Oconto	T066 — Washington
T019 — Florence	T043 — Oneida	T067 — Waukesha
T020 — Fond du Lac	T044 — Outagamie	T068 — Waupaca
T021 — Forest	T045 — Ozaukee	T069 — Waushara
T022 — Grant	T046 — Pepin	T070 — Winnebago
T023 — Green	T047 — Pierce	T071 — Wood
T024 — Green Lake	T048 — Polk	T072 — Menominee
For out-of-state points of origin, use code T073		

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Glossary of Common Terms

Adjustment

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

Allowed status

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

BadgerCare

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

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

Base rate

The first five miles traveled by the specialized medical vehicle (SMV), beginning at the pick-up point and including the following services:

- Dispatch of the SMV to the recipient pick-up point.
- Escort of the recipient to and from the front door of the pick-up point and drop-off point.

CESA

Cooperative Educational Service Agency. The organization responsible for submitting claims to Wisconsin Medicaid for specialized medical vehicle (SMV) services provided as part of the school-based services (SBS) benefit.

CMS

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

Common carrier

Any mode of transportation, other than an ambulance or specialized medical vehicle (SMV), approved by the county/tribal social or human services department, W-2 agency, or outstation site.

CPT

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

Crossover claim

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

DHCF

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

DHFS

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

DHHS

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

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

Direct Route

The shortest route between a recipient pick-up point and the recipient's destination.

DOS

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

Drop-off point

Location to which a specialized medical vehicle (SMV) transports a recipient.

Dual entitlee

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

ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

Emergency services

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

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Reports and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Extended travel

Trips whose mileage extends beyond the upper mileage limit set by Wisconsin Medicaid.

Fee-for-service

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

Fiscal agent

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

HCFA

Health Care Financing Administration. *Please refer to the definition under CMS.*

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national

alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as HCFA Common Procedure Coding System.

HealthCheck

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

ICD-9-CM

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

IEP

Individualized Education Program. A written statement for a child with a disability that is developed, reviewed, and revised in accordance with s. 115.787, Wis. Stats. The IEP guides the delivery of special education supports and services for a child with a disability.

Indefinite disability

A chronic physical or mental impairment which includes an inability to move about without personal assistance or mechanical aids (for example, a wheelchair, walker, or crutches) as defined in HFS 107.23(1)(c)1, Wis. Admin. Code.

Maximum allowable fee schedule

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

Medicaid

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

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

Medically necessary

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

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

Mileage

Any miles traveled by the specialized medical vehicle (SMV) beyond those included in the base rate.

Multiple carry

A trip in which a specialized medical vehicle (SMV) transports two or more Wisconsin Medicaid recipients at the same time.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

Pick-up point

The location at which a specialized medical vehicle (SMV) first picks up a recipient for transportation to or from a Medicaid-covered medical service.

POS

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

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

Temporary disability

A disability that is not indefinite or permanent and is expected to exist only for a limited time.

TOS

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

Trip

The distance from the recipient's pick-up point to the recipient's drop-off point.

Unloaded mileage

Mileage over 20 miles traveled to pick up the recipient for transport to or from Medicaid-covered services.

Waiting time

When a specialized medical vehicle (SMV) provider waits for the recipient to return while the recipient receives medical services.

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