ForwardHealth
Wisconsin serving you

Update
February 2010

No. 2010-05

Affected Programs: BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, Medicaid
To: Nursing Homes, HMOs and Other Managed Care Programs

Reimbursement and Claims Submission Changes for Nursing Home Provided Non-emergency Transportation for Nursing Home Residents

Effective for dates of service on and after March 1, 2010, Wisconsin Medicaid and BadgerCare Plus will change the reimbursement and claims submission for Nursing Home provided non-emergency transportation for nursing home residents.

Reimbursement and Claim Submission Changes

Based on a 2008 Legislative Audit Bureau audit Wisconsin Medicaid and BadgerCare Plus must implement changes to the reimbursement for nursing home provided non-emergency transportation. Effective for dates of service (DOS) on and after March 1, 2010, Wisconsin Medicaid and BadgerCare Plus will implement changes to the reimbursement and claims submission for nursing home provided non-emergency transportation for residents enrolled in Wisconsin Medicaid, BadgerCare Plus Standard Plan, and BadgerCare Plus Benchmark Plan.

Non-emergency transportation is defined in the Methods of Implementation for Wisconsin Medicaid Nursing Home Payment Rates for the Period August 1, 2009 Through June 30, 2010 as:

> Transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by common carrier such as bus or taxi.

The following changes will be made:

- Claims for Nursing Home provided non-emergency transportation must be submitted on the 1500 Health Insurance Claim Form or the 837 Health Care Claim: Professional (837P) transaction.
- Nursing home providers will submit claims using Healthcare Common Procedure Coding System (HCPCS) procedure codes for nursing home provided non-emergency transportation.

Procedure Code Changes for Non-emergency Transportation

Effective for DOS on and after March 1, 2010, providers are required to use one or both of the following HCPCS procedure codes on claims for nursing home provided non-emergency transportation:

- Indicate procedure code A0120 (Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems) to be reimbursed for a base rate.

- ✓ Indicate a unit of "1" to reflect one DOS. Providers will be reimbursed for only one base rate per DOS regardless of the number of trips or appointments a member had on that DOS.
- ✓ Indicate the usual and customary charge for the service.
- ✓ The maximum amount nursing home providers will be reimbursed is $10.00 per DOS.

- Indicate procedure code S0215 (Non-emergency transportation; mileage per mile) to be reimbursed for mileage.
  - ✓ Indicate the total miles traveled for the single DOS (1.0 mile = 1.0 unit).
  - ✓ Indicate the usual and customary charge for the total mileage.
  - ✓ Providers will be reimbursed $1.00 per mile.

Effective for DOS on and after March 1, 2010, ForwardHealth will no longer reimburse revenue code 0960 (Professional fees: general classification).

When nursing home providers transport more than one member a claim may be submitted for the base rate and mileage for each resident transported.

Claim Form Change

Effective for DOS on and after March 1, 2010, providers are required to submit claims for non-emergency transportation on the 1500 Health Insurance Claim Form or by 837P transaction.

For 1500 Health Insurance Claim Form instructions for non-emergency transportation see Attachment 1 of this *ForwardHealth Update.* For a sample copy of the 1500 Health Insurance Claim Form for non-emergency transportation see Attachment 2.

Place of Service

Providers should indicate place of service code 31 (Skilled Nursing Facility) or 32 (Nursing Facility).

Nursing Homes Contracting with a Common Carrier Service

Nursing home providers who contract with a common carrier (e.g., bus, taxi) service and are only billed a flat rate by the common carrier should only indicate the procedure code for the base rate, procedure code A0120 on the claim. Providers should indicate a unit of "1" in the "DAYS or UNITS" element but include the total cost for the day in the "$ CHARGES" element.

Nursing home providers who contract with a common carrier service and are billed a base rate plus mileage would use both procedure code A0120 and S0215. Indicate the base rate fee on the detail with procedure code A0120 and the mileage on the detail with S0215.

Required Documentation

Providers are required to document the name and address of the medical facility to which the member was transported and the total number of miles to and from the facility. Providers are required to maintain documentation of every transport.

Transportation Provided to Dual Eligible Members During Coinsurance Days

Providers submitting claims for non-emergency transportation provided to dually eligible members should submit a claim directly to ForwardHealth.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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ATTACHMENT 1
1500 Health Insurance Claim Form Completion Instructions for Nursing Home Non-emergency Transportation Services

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

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about verifying enrollment.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other

Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number

Enter the member's identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct member ID.

Element 2 — Patient's Name

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

Element 3 — Patient's Birth Date, Sex

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

Element 4 — Insured's Name

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

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

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or 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)

Element 17 — Name of Referring Provider or Other Source (not required)

Element 17a (not required)

Element 17b — NPI (not required)

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? $Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24

The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Element 24A — Date(s) of Service

Enter to and from dates of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the place of service (POS), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

Element 24B — Place of Service

Enter POS code 31 or 32 for each service performed.

Element 24C — EMG (not required)

Element 24D — Procedures, Services, or Supplies

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

Element 24E — Diagnosis Pointer

Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill BadgerCare Plus their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to BadgerCare Plus benefits.

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

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

Enter a "Y" for each family planning procedure. If family planning does not apply, leave this element blank.

Note: Providers should *not* use this element to indicate that a service is a result of a HealthCheck referral.

Element 24I — ID Qual [Not Required]

If the rendering provider's National Provider Identifier (NPI) is different than the billing provider number in Element 33A, enter a qualifier of "ZZ," indicating provider taxonomy, in the *shaded area* of the detail line.

If the rendering provider is exempt from the NPI requirement, enter a qualifier of "1D," indicating provider number.

Element 24J — Rendering Provider ID. # (not required)

Element 25 — Federal Tax ID Number (not required)

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

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or 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/CCYY format.

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

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code.

Element 33a — NPI

Enter the NPI of the billing provider.

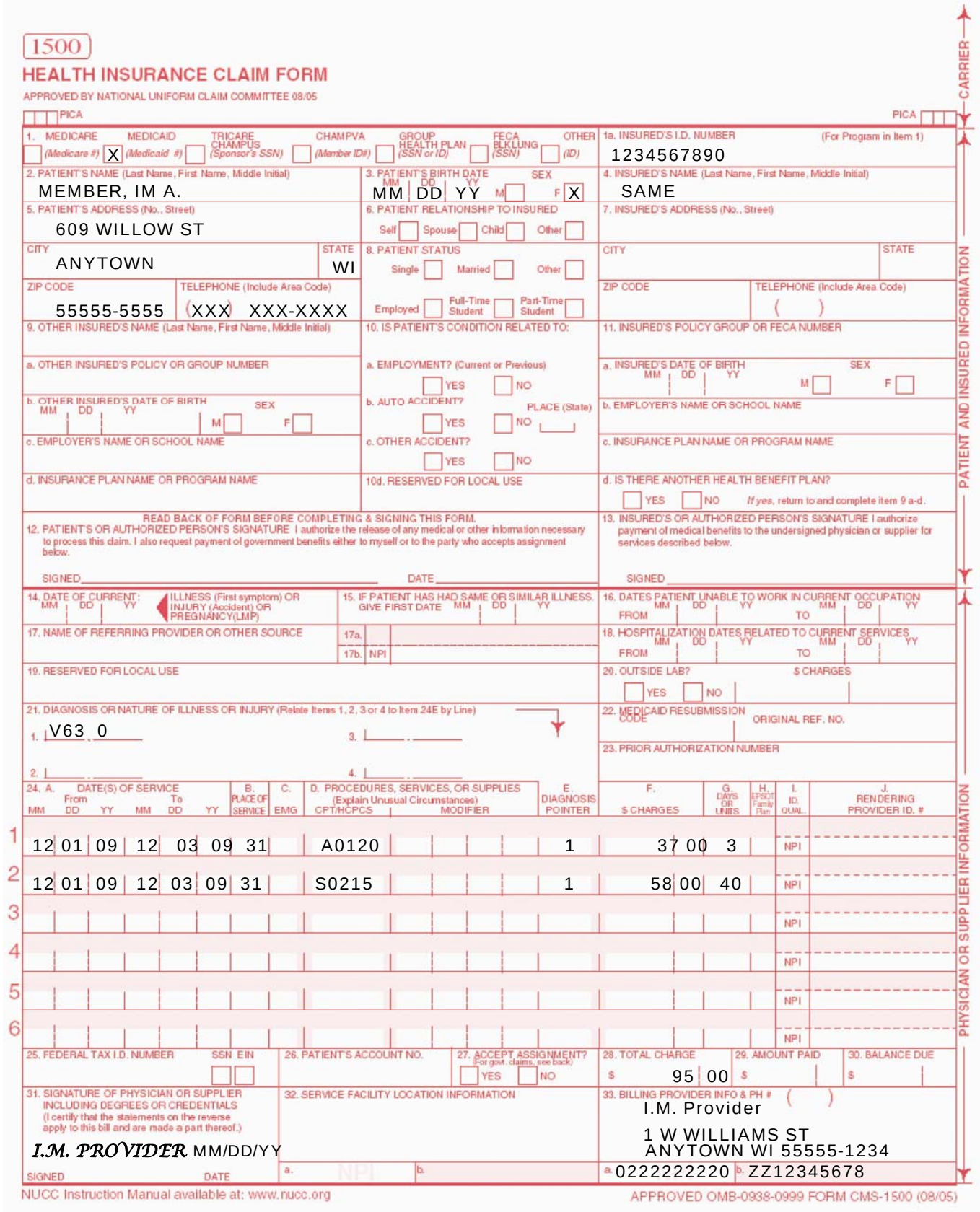
Element 33b

Enter qualifier "ZZ" followed by the 10-digit provider taxonomy code.

Do not include a space between the qualifier "ZZ" and the provider taxonomy code.

ATTACHMENT 2
Sample 1500 Health Insurance Claim Form for Nursing Home Non-emergency Transportation Services

(A copy of the "Sample 1500 Health Insurance Claim Form for Nursing Home Non-emergency Transportation Services" is located on the following page.)



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | 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): MEMBER, IM A.

3. PATIENT'S BIRTH DATE MM DD YY SEX: M [ ] F [X]

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

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

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: 55555-5555 | 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 PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 01 09	12 03 09	31		A0120		1	37 00	3		NPI
2	12 01 09	12 03 09	31		S0215		1	58 00	40		NPI
3											NPI
4											NPI
5											NPI
6											NPI

PATIENT AND INSURED INFORMATION

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 $ 95 00

29. AMOUNT PAID $

30. BALANCE DUE $

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. PROVIDER MM/DD/YY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. Provider

1 W WILLIAMS ST

ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ12345678

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)