wisconsin Medicaid update
and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Home Health Agencies
Individual Medical Supply Providers
Medical Equipment Vendors
Pharmacies
HMOs and Other Managed Care Programs

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

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

Changes to paper claims and prior authorization for enteral nutrition products as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to paper claims and prior authorization (PA) for enteral nutrition products, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising Medicaid PA request forms and instructions.

A separate *Update* will notify providers of the specific dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for enteral nutrition products. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A separate *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements), but include:

- Adopting nationally recognized procedure codes and place of service (POS) codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising PA request forms and instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes, revised paper claim instructions, or revised PA forms and instructions prior to implementation dates may result in claim denials and returned PA requests. Specific implementation dates will be published in a separate *Update.*

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for enteral nutrition products.

Allowable procedure codes

Wisconsin Medicaid will adopt nationally recognized codes to replace currently used Wisconsin Medicaid local procedure codes (XX030-XX082) for enteral nutrition products.

Refer to Attachment 1 of this *Update* for the nationally recognized procedure codes. Attachment 2 lists common enteral nutrition products in alphabetical order along with the corresponding nationally recognized procedure codes. Providers will be required to use the appropriate procedure code that describes the product.

Modifiers

Providers will be required to use nationally recognized *Current Procedural Terminology* modifier "22" (Unusual procedural services) for enteral nutrition products taken orally. For products administered other than orally, no modifier is required.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 3 for a list of allowable POS codes after HIPAA implementation.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified providers of enteral nutrition products will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 4 for the revised instructions. Attachment 5 is a sample of a claim for enteral nutrition products that reflects the changes to the billing instructions.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the CMS 1500 claim form instructions

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Medicare disclaimer codes were revised (Element 11).
- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).

Revision of prior authorization request forms and instructions

Unlisted Products

When submitting a request for PA, providers may call Sandmerc at (877) 735-1326 for product codes not listed in Attachments 1 and 2. If the product is not listed in Attachment 1 or 2 and there is no Sandmerc code, providers should enter "NO CODE" in Element 16 of the Prior Authorization Request Form (PA/RF). Wisconsin Medicaid will indicate the appropriate procedure code for use on the claim form.

Revised Prior Authorization Request Form

With the implementation of HIPAA, providers of enteral nutrition products will be required to use the revised PA/RF, HCF 11018, dated 06/03. Instructions for completion of this revised form are located in Attachment 6. A sample PA/RF is in Attachment 7.

In the revision of the PA/RF, a field for the requested start date was added (Element 14).

Prior authorization attachments

The Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), HCF 11054, dated 07/03, has also been revised. This form has been renamed from the Prior Authorization/Drugs/DMS Attachment for Enteral Nutrition

Providers will be required to use nationally recognized *Current Procedural Terminology* modifier "22" (Unusual procedural services) for enteral nutrition products taken orally.

The PA/ENPA is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site.

Products (PA/DGA). The basic information requested on the form has not changed; only the format and title of the form has changed. Refer to Attachment 8 for a copy of the completion instructions for the PA/ENPA. Attachment 9 is a copy of the PA/ENPA for providers to photocopy.

Obtaining prior authorization request forms

The PA/ENPA is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique preprinted PA number on it.) To access the PA/ENPA and other Medicaid forms, follow these instructions:

1. Go to *www.dhfs.state.wi.us/medicaid/*.
2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader®* and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/ENPA or PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the HCF number of the form (if applicable) and send the request to:

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

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

ATTACHMENT 1
Enteral nutrition product procedure code and maximum allowable fees list

(Effective for dates of service on and after October 1, 2003)

The following table lists common enteral nutrition products alphabetically along with the corresponding maximum fees per unit. *Note:* This is not a comprehensive list.

B4150 Enteral formulae; category I; semi-synthetic intact protein/protein isolates, administered through an enteral feeding tube, 100 calories = 1 unit					
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**	**Product Name**	**Max fee/ Unit**
AMTF	$0.62	Isocal	$0.62	Nutren Junior	$0.62
AMTF Diabetic	$0.62	Isocal HN	$0.62	Nutren Junior with Fiber	$0.62
AMTF High Protein	$0.62	Isocal HN Plus	$0.62	Nutren VHP	$0.62
AMTF Pediatric	$0.62	Isocal II	$0.62	Nutri-Drink	$0.62
Boost	$0.62	Isofiber	$0.62	Nutrilan	$0.62
Boost High Protein	$0.62	Isolan	$0.62	Nutripak	$0.62
Boost with Fiber	$0.62	Isosource	$0.62	Nutrition	$0.62
Ensure	$0.62	Isosource HN	$0.62	Osmolite	$0.62
Ensure HN	$0.62	Jevity	$0.62	Osmolite HN	$0.62
Ensure HP	$0.62	Jevity Plus	$0.62	Osmolite HN Plus	$0.62
Ensure Powder	$0.62	Jevity RTH	$0.62	Pediasure	$0.62
Ensure with Fiber	$0.62	Kindercal	$0.62	Pediasure with Fiber	$0.62
Entera	$0.62	Lonalac	$0.62	Portagen	$0.62
Entera Isotonic	$0.62	Meritene	$0.62	Pre-Attain	$0.62
Entera Isotonic Fiber	$0.62	Naturite	$0.62	ProBalance	$0.62
Enteralife HN	$0.62	Newtrition (Flavors)	$0.62	Promote	$0.62
Enteralife HN Fiber	$0.62	Newtrition HN	$0.62	Promote with Fiber	$0.62
Enteralife HN-2	$0.62	Newtrition Isofiber	$0.62	Resource	$0.62
Entrition HN	$0.62	Newtrition Isotonic	$0.62	Resource Diabetic	$0.62
Fiberlan	$0.62	Nitrolan (Nitro-Pro)	$0.62	ReSource Just for Kids with Fiber	$0.62
Fibersource	$0.62	NuBasics	$0.62	Susta II	$0.62
Fibersource HN	$0.62	NuBasics VHP	$0.62	Sustacal	$0.62
Fortison	$0.62	NuBasics with Fiber	$0.62	Sustacal Basic	$0.62
Glytrol	$0.62	Nutramigen	$0.62	Sustacal Fiber	$0.62
Hearty Balance	$0.62	Nutren 1.0	$0.62	Ultracal	$0.62
Introlite	$0.62	Nutren 1.0 with Fiber	$0.62	Ultracal HN Plus	$0.62

B4151 Enteral formulae; category I: natural intact protein/protein isolates, administered through an enteral feeding tube, 100 calories = 1 unit					
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**	**Product Name**	**Max fee/Unit**
Compleat Pediatric	$1.45	Compleat-B Modified	$1.45	Vitaneed	$1.45
Compleat-B	$1.45				

B4152 Enteral formulae; category II: intact protein/protein isolates (calorically dense), administered through an enteral feeding tube, 100 calories = 1 unit					
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**	**Product Name**	**Max fee/Unit**
AMTF High Cal 2.0	$0.52	Isotera Isotonic	$0.52	Nutri-Drink Plus	$0.52
AMTF Pulmonary	$0.52	Naturite Plus	$0.52	Nutrition Plus	$0.52
AMTF Renal 2.0	$0.52	Newtrition 1.5	$0.52	Resource Plus	$0.52
Boost Plus	$0.52	Novasource 2.0	$0.52	Respalor	$0.52
Comply	$0.52	NovaSource Pulmonary	$0.52	Sustacal HC	$0.52
Deliver 2.0	$0.52	NuBasics 2.0 Complete	$0.52	Sustacal Plus	$0.52
Ensure Plus	$0.52	NuBasics Plus	$0.52	Twocal HN	$0.52
Ensure Plus HN	$0.52	Nutren 1.5	$0.52	Ultralan	$0.52
Entrition 1.5	$0.52	Nutren 2.0	$0.52		
IsoSource 1.5	$0.52	NutriAssist 1.5	$0.52		

B4153 Enteral formulae; category III: hydrolized protein/amino acids, administered through an enteral feeding tube, 100 calories = 1 unit					
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**	**Product Name**	**Max fee/ Unit**
Accupepha	$1.76	Neocate Infant Formula	$1.76	Precision Isotera	$1.76
Criticare HN	$1.76	Neocate One+Liquid	$1.76	Reabilan	$1.76
EleCare	$1.76	Neocate One+Powder	$1.76	Subdue	$1.76
Glutasorb	$1.76	Optimental	$1.76	Travasorb HN	$1.76
Isotein	$1.76	Peptamen 1.5	$1.76	Vital HN	$1.76
L-Emental	$1.76	Peptical	$1.76	Vivonex HN	$1.76
L-Emental Pediatric	$1.76	Precision HN	$1.76	Vivonex Pediatric	$1.76

B4154 Enteral formulae; category IV: defined formula for special metabolic need, administered through an enteral feeding tube, 100 calories = 1 unit					
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**	**Product Name**	**Max fee/ Unit**
Accupep HPF	$1.13	Isosource VHN	$1.13	Pro-Peptide for Kids	$1.13
Acerflex	$1.13	L-Emental Hepatic	$1.13	Pro-Peptide VHN	$1.13
Advera	$1.13	L-Emental Plus	$1.13	Protain XL	$1.13
Alitraq	$1.13	Lipisorb	$1.13	Provide	$1.13
AminAid	$1.13	Magnacal	$1.13	Pulmocare	$1.13
AMTF Renal	$1.13	Magnacal Renal	$1.13	Reabilan HN	$1.13
AMTF Trauma	$1.13	Maxamaid Formulas	$1.13	Renalcal	$1.13
Analog Formulas	$1.13	Maxamum Formulas	$1.13	Replete	$1.13
Choice DM	$1.13	Nepro	$1.13	Replete with Fiber	$1.13
Citrotein	$1.13	Novasource Renal	$1.13	Resource for Kids	$1.13
Crucial	$1.13	NutriHep	$1.13	SandoSource Peptide	$1.13
DiabetiSource	$1.13	Nutrivent	$1.13	SLD	$1.13
Entera OPD	$1.13	Oxepa	$1.13	Stresstein	$1.13
Fulfil	$1.13	Peptamen	$1.13	Suplena (Replena)	$1.13
Glucerna	$1.13	Peptamen VHP	$1.13	Traumacal	$1.13
Gluco-Pro	$1.13	Peptamin Junior	$1.13	Travasorb Hepatic	$1.13
Hepatic-Aid	$1.13	Perative	$1.13	Travasorb MCT	$1.13
Immun-Aid	$1.13	Periflex	$1.13	Travasorb Renal	$1.13
Impact	$1.13	Pregestimil	$1.13	Vivonex Plus	$1.13
Impact 1.5	$1.13	Pro-Peptide	$1.13	Vivonex T.E.N.	$1.13
Impact with Fiber	$1.13				

B4155 Enteral formulae; category V: modular components, administered through an enteral feeding tube, 100 calories = 1 unit					
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**	**Product Name**	**Max fee/ Unit**
Casec	$0.88	Microlipid	$0.88	Propac Plus	$0.88
Elementra	$0.88	Moducal	$0.88	ProSource Protein	$0.88
Essential ProPlus	$0.88	Phlexy-10 Drink Mix	$0.88	RCF (Ross Carb Free)	$0.88
Essential Protein	$0.88	Polycose	$0.88	ReSource Instant Protein Powder	$0.88
Fibrad	$0.88	Procare	$0.88	Restore-X	$0.88
Hi ProCal	$0.88	ProCell Protein	$0.88	SoyPro	$0.88
Immunocal	$0.88	Promix	$0.88	Sumacal	$0.88
MCT Oil	$0.88	ProMod	$0.88	Sysco Classic Lactose Free Procal	$0.88

B4156 Enteral formulae; category VI: standardized nutrients, administered through an enteral feeding tube, 100 calories = 1 unit			
Product name	**Max fee/ Unit**	**Product name**	**Max fee/ Unit**
Precision LR Powder	$1.25	Travasorb STD Powder	$1.25
Tolerex	$1.25	Vivonex STD Powder	$1.25

Note:

- Providers may call Sandmerc at (877) 735-1326 for product codes not listed in this attachment.
- If there is no code for the product being submitted for prior authorization (PA), submit the request using “NO CODE” in the procedure code field.
- If the product is to be taken orally, submit the PA request with the appropriate code plus the modifier “22.”

ATTACHMENT 2
Enteral nutrition product alphabetical list

(Effective for dates of service on and after October 1, 2003)

The following table lists common enteral nutrition products alphabetically along with the corresponding nationally recognized procedure codes. *Note:* This is not a comprehensive list.

Product name	Code
Accupep HPF	B4154
Accupepha	B4153
Acerflex	B4154
Advera	B4154
Alitraq	B4154
AminAid	B4154
AMTF	B4150
AMTF Diabetic	B4150
AMTF High Cal 2.0	B4152
AMTF High Protein	B4150
AMTF Pediatric	B4150
AMTF Pulmonary	B4152
AMTF Renal	B4154
AMTF Renal 2.0	B4152
AMTF Trauma	B4154
Analog Formulas	B4154
Boost	B4150
Boost High Protein	B4150
Boost Plus	B4152
Boost with Fiber	B4150
Casec	B4155
Choice DM	B4154
Citrotein	B4154
Compleat Pediatric	B4151
Compleat-B	B4151
Compleat-B Modified	B4151
Comply	B4152
Criticare HN	B4153

Product name	Code
Crucial	B4154
Deliver 2.0	B4152
DiabetiSource	B4154
EleCare	B4153
Elementra	B4155
Ensure	B4150
Ensure HN	B4150
Ensure HP	B4150
Ensure Plus	B4152
Ensure Plus HN	B4152
Ensure Powder	B4150
Ensure with Fiber	B4150
Entera	B4150
Entera Isotonic	B4150
Entera Isotonic Fiber	B4150
Entera OPD	B4154
Enteralife HN	B4150
Enteralife HN Fiber	B4150
Enteralife HN-2	B4150
Entrition 1.5	B4152
Entrition HN	B4150
Essential ProPlus	B4155
Essential Protein	B4155
Fiberlan	B4150
Fibersource	B4150
Fibersource HN	B4150
Fibrad	B4155
Fortison	B4150

Product Name	Code
Fulfil	B4154
Glucerna	B4154
Gluco-Pro	B4154
Glutasorb	B4153
Glytrol	B4150
Hearty Balance	B4150
Hepatic-Aid	B4154
Hi ProCal	B4155
Immun-Aid	B4154
Immunocal	B4155
Impact	B4154
Impact 1.5	B4154
Impact with Fiber	B4154
Introlite	B4150
Isocal	B4150
Isocal HN	B4150
Isocal HN Plus	B4150
Isocal II	B4150
Isofiber	B4150
Isolan	B4150
Isosource	B4150
Isosource 1.5	B4152
Isosource HN	B4150
Isosource VHN	B4154
Isotein	B4153
Isotera Isotonic	B4152
Jevity	B4150
Jevity Plus	B4150

Product name	Code
Jevity RTH	B4150
Kindercal	B4150
L-Emental	B4153
L-Emental Hepatic	B4154
L-Emental Plus	B4154
Lipisorb	B4154
Lonalac	B4150
Magnacal	B4154
Magnacal Renal	B4154
Maxamaid Formulas	B4154
Maxamum Formulas	B4154
MCT Oil	B4155
Meritene	B4150
Microlipid	B4155
Moducal	B4155
Naturite	B4150
Naturite Plus	B4152
Neocate Infant Formula	B4153
Neocate One+ Liquid	B4153
Neocate One+ Powder	B4153
Nepro	B4154
Newtrition (Flavors)	B4150
Newtrition 1.5	B4152
Newtrition HN	B4150
Newtrition Isofiber	B4150
Newtrition Isotonic	B4150
Nitrolan (Nitro-Pro)	B4150
NovaSource 2.0	B4152
NovaSource Pulmonary	B4152
Novasource Renal	B4154

Product name	Code
NuBasics	B4150
NuBasics 2.0 Complete	B4152
NuBasics Plus	B4152
NuBasics VHP	B4150
Nutramigen	B4150
Nutren 1.0	B4150
Nutren 1.0 with Fiber	B4150
Nutren 1.5	B4152
Nutren 2.0	B4152
Nutren Junior	B4150
Nutren Junior with Fiber	B4150
Nutren VHP	B4150
NutriAssist 1.5	B4152
Nutri-Drink	B4150
Nutri-Drink Plus	B4152
NutriHep	B4154
Nutrilan	B4150
Nutripak	B4150
Nutrition	B4150
Nutrition Plus	B4152
Nutrivent	B4154
Optimental	B4153
Osmolite	B4150
Osmolite HN	B4150
Osmolite HN Plus	B4150
Oxepa	B4154
Pediasure	B4150
Pediasure with Fiber	B4150
Peptamen	B4154
Peptamen 1.5	B4153

Product name	Code
Peptamen VHP	B4154
Peptamin Junior	B4154
Peptical	B4153
Perative	B4154
Phlexy-10 Drink Mix	B4155
Polycose	B4155
Portagen	B4150
Pre-Attain	B4150
Precision HN	B4153
Precision Isotera	B4153
Precision LR Powder	B4156
Pregestimil	B4154
ProBalance	B4150
Procare	B4155
ProCell Protein	B4155
Promix	B4155
ProMod	B4155
Promote	B4150
Promote with Fiber	B4150
Propac Plus	B4155
Pro-Peptide	B4154
Pro-Peptide for Kids	B4154
Pro-Peptide VHN	B4154
ProSource Protein	B4155
Protain XL	B4154
Provide	B4154
Pulmocare	B4154
RCF (Ross Carb Free)	B4155
Reabilan	B4153
Reabilan HN	B4154

Product name	Code
Renalcal	B4154
Replete	B4154
Replete with Fiber	B4154
ReSource	B4150
ReSource Diabetic	B4150
ReSource For Kids	B4154
ReSource Instant Protein Powder	B4155
ReSource Just For Kids with Fiber	B4150
ReSource Plus	B4152
Respalor	B4152
Restore-X	B4155
SandoSource Peptide	B4154
SLD	B4154
SoyPro	B4155
Stresstein	B4154

Product name	Code
Subdue	B4153
Sumacal	B4155
Suplena (Replena)	B4154
Susta II	B4150
Sustacal	B4150
Sustacal Basic	B4150
Sustacal Fiber	B4150
Sustacal HC	B4152
Sustacal Plus	B4152
Sysco Classic Lactose Free ProCal	B4155
Tolerex	B4156
Traumacal	B4154
Travasorb Hepatic	B4154
Travasorb HN	B4153
Travasorb MCT	B4154

Product name	Code
Travasorb Renal	B4154
Travasorb STD Powder	B4156
Twocal HN	B4152
Ultracal	B4150
Ultracal HN Plus	B4150
Ultralan	B4152
Vital HN	B4153
Vitaneed	B4151
Vivonex HN	B4153
Vivonex Pediatric	B4153
Vivonex Plus	B4154
Vivonex STD Powder	B4156
Vivonex T.E.N.	B4154

ATTACHMENT 3
Place of service codes
for enteral nutrition products

The following table lists the nationally recognized procedure codes that providers will be required to use when submitting claims for enteral nutrition products. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
50	Federally Qualified Health Center
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 4
CMS 1500 claim form instructions for enteral nutrition products

(For claims submitted after HIPAA implementation)

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

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

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

Element 1a — Insured's I.D. Number

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

Element 2 — Patient's Name

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

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

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

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

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

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

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

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

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

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

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

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

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

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

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.

Code	Description
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

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

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

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

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

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

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

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

Element 19 — Reserved for Local Use

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

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

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

Element 22 — Medicaid Resubmission (not required)

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

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

Element 24A — Date(s) of Service

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

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing **only** the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

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

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge **per detail line** in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Wisconsin Medicaid denies claims received without an appropriate POS code.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

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

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

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

Element 24F — $ Charges

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

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan

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

Element 24I — EMG

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

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

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

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

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

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

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (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 (not required)

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

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

ATTACHMENT 5
Sample CMS 1500 claim form for enteral nutrition products

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [D] / 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 [X] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] 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: M-7

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 FROM MM DD YY TO MM DD YY

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

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 783.41
2.
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 12 01 03	12		B4150	1	XX XX	120.0				
2										
3										
4										
5										
6										

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

26. PATIENT'S ACCOUNT NO.: 1234JED

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

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XX XX

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

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#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 6
Prior Authorization Request Form (PA/RF) Completion Instructions for enteral nutrition products

(For prior authorization requests submitted after HIPAA implementation)

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

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

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the submitted claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type "131" (for enteral nutrition products). The processing type is a three-digit code used to identify a category of service requested.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

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

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1996, would be 09/08/96).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

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

Element 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description (not required)

Element 14 — Requested Start Date

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested.

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code

Enter the appropriate procedure code for each product requested. For unlisted product codes, enter "NO CODE" in this Element. Wisconsin Medicaid will indicate the appropriate code for use on the claim form.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS

Enter the appropriate place of service code designating where the requested product would be provided/performed/dispensed.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate procedure code for each product requested.

Element 20 — QR

Enter the appropriate number of units requested for the product requested — one unit = 100 calories.

Element 21 — Charge

Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

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

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 7
Sample Prior Authorization Request Form (PA/RF) for enteral nutrition products

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider 1 W. Williams Anytown, WI 55555	(XXX) XXX-XXXX 4. Billing Provider's Medicaid Provider Number 87654321	131

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	MM/DD/YY	1234 Street St. Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Ima A.	9. Sex — Recipient ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
783.41 Failure to thrive		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date MM/DD/YY	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	B4150					12	Pediasure with Fiber (120 units/month)	1440	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** XXX.XX

23. **SIGNATURE** — Requesting Provider I.M. Authorized

24. Date Signed MM/DD/YY

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

❑ Approved

__________ Grant Date __________ Expiration Date

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

SIGNATURE — Consultant / Analyst

Date Signed

ATTACHMENT 8
Prior Authorization / Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions

(A copy of the "Prior Authorization/Enteral Nutrition Product Attachment [PA/ENPA] Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA) COMPLETION INSTRUCTIONS

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

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

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

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

Attach the completed Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

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

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

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth.

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — TYPE OF REQUEST

Element 4
Indicate the start date requested for PA or the date the prescription was filled.

Element 5
Check the appropriate box to indicate if this product has been requested previously.

SECTION III — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 6 — Product Name
Enter the product name.

Element 7 — Quantity Ordered
Enter the quantity that was ordered.

Element 8 — Date Order Issued
Enter the date the order was issued.

Element 9 — Directions for Use of Product
Enter the directions for use of the drug.

Element 10 — Daily Dose
Enter the daily dose.

Element 11 — Refills
Enter the amount of refills.

Element 12 — Name — Prescriber
Enter the name of the prescriber.

Element 13 — Drug Enforcement Administration Number
Enter the Drug Enforcement Administration number. These codes must *not* be used for prescriptions for controlled substances.

SECTION IV — CLINICAL INFORMATION

Include diagnostic, as well as clinical, information explaining the need for the product requested.

Element 14
List the recipient's condition the product is intended to treat. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

Element 15
Indicate source of clinical information.

Element 16
Indicate use of the product requested.

Element 17
Indicate dosage of the product requested.

SECTION V — ADDITIONAL INFORMATION REQUIRED FOR ENTERAL NUTRITION SUPPLEMENTS

Element 18
Enter the percentile (children only) and the height. If this is other than the first request, please include the first measurements from the initial request as well as the current information.

Element 19
Enter the percentile (children only) and the weight. If this is other than the first request, please include the first measurements from the initial request as well as the current information.

Element 20
Enter the amount of weight loss, if any, and within what specific time span.

Element 21
Check all that apply.

Element 22 — Signature — Pharmacist
The pharmacist/dispenser must review this information and sign this form.

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

Element 24
Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Be sure to indicate a fax or telephone number if selecting either of these options.

ATTACHMENT 9
Prior Authorization / Enteral Nutrition Product Attachment (PA/ENPA)
(for photocopying)

(A copy of the "Prior Authorization/Enteral Nutrition Product Attachment [PA/ENPA]" [for photocopying] is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11054 (Rev. 07/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions (HCF 11054A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — TYPE OF REQUEST

4. Indicate the start date requested or the date the prescription was filled (required).

5. Check one:

❑ This is an initial PA request for this drug, for this recipient, by this provider.
❑ This is a request to renew or extend previously approved PA for therapy using this drug.

First PA number___________________________

❑ This is a request to change or add a new National Drug Code (NDC) number to a current valid PA.

First PA number___________________________ NDC number to add ________________________________

SECTION III — PRESCRIPTION INFORMATION

6. Product Name	7. Quantity Ordered
8. Date Order Issued	9. Directions for Use of Product
10. Daily Dose	11. Refills
12. Name — Prescriber	13. Drug Enforcement Administration Number

Continued

SECTION IV — CLINICAL INFORMATION

14. List the recipient's condition the prescribed drug is intended to treat. Include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis for pharmaceutical care recipients. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

15. Indicate source for clinical information (check one).

- ☐ This information was primarily obtained from the prescriber or prescription order.
- ☐ This information was primarily obtained from the recipient.
- ☐ This information was primarily obtained from some other source (specify). ____

____

____

16. Use (check one)

- ☐ Compendial standards, such as the United States Pharmacopeia - Dispensing Information (USP-DI) or drug package insert, lists the intended use identified above as an expected indication.
- ☐ Compendial standards, such as the USP-DI, lists the intended use identified above as a [bracketed] accepted application.
- ☐ Compendial standards, such as the USP-DI or drug package insert, lists the intended use identified above as an expected use.
- ☐ The intended use above is not listed in compendial standards. Peer-reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.)

17. Dose (check one)

- ☐ The daily dose and duration are within compendial standards of general prescribing or dosing limits for the indicated use.
- ☐ The daily dose and duration are **not** within compendial standards of general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

Continued

SECTION V — ADDITIONAL INFORMATION REQUIRED FOR ENTERAL NUTRITION SUPPLEMENTS

18. Indicate percentile (children only) and height.	19. Indicate percentile (children only) and weight.

20. Indicate the amount of weight loss, if any, and within what specific time span the weight was lost.

21. Check all that apply.

- ☐ This recipient is tube-fed.
- ☐ If not tube-fed, number of Kcal prescribed per day _________. Percent of total calories from this supplement ________%.
- ☐ This recipient can consume most normal table foods.
- ☐ This recipient can consume softened, mashed, or pureed food, or food prepared by blender.
- ☐ This recipient has a clinical condition, as indicated in Section IV, which prevents him or her from consuming normal table, and softened, mashed, or pureed food or food prepared by blender.
- ☐ Comprehensive documentation of this recipient's condition is presented previously in Section IV.
- ☐ This recipient is eligible for food stamps.
- ☐ This product or a similar product can be obtained from the Women, Infants, and Children program.

22. **SIGNATURE** — Pharmacist	23. Date Signed

24. Please notify me of approval / denial by:

- ☐ Fax (include Fax number) ____
- ☐ Telephone (include telephone number) ____
- ☐ No special notice needed.