wisconsin Medicaid update and BadgerCare

June 2004 ● No. 2004-46

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Audiologists

Hearing Instrument Specialists

Speech and Hearing Clinics

HMOs and Other Managed Care Programs

Revised Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) Form Available

Wisconsin Medicaid has a revised Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) form available for providers. Providers are encouraged to use the new form immediately; however, Wisconsin Medicaid will continue to accept forms with a revision date of 06/03.

New Prior Authorization Request/ Hearing Instrument and Audiological Services (PA/HIAS2) Form Available

Wisconsin Medicaid has revised the Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) form. The new form corrects errors on the pure tone audiogram (Element 15) and adds space for a printed provider name (Element 19). Providers may use the new form immediately; however, Wisconsin Medicaid will also continue to accept forms with a revision date of 06/03 until providers' supplies of the form with this revision date are depleted. See Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for the revised PA/HIAS2 instructions and Attachment 2 for a sample of the revised PA/HIAS2 form.

Submission of the Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) Form by Mail

Effective immediately, providers are required to submit the PA/HIAS2 to Wisconsin Medicaid on the three-ply form when submitting by mail. Photocopies of the completed PA/HIAS2 will *not* be accepted when the request is mailed. The July 2003 *Update* (2003-56), titled "Changes to paper claims and prior authorization for hearing instruments and hearing services as a result of HIPAA," incorrectly stated that providers may submit a photocopy of the PA/HIAS2 to Wisconsin Medicaid for processing.

Obtaining Prior Authorization Forms

The revised PA/HIAS2 is available from Wisconsin Medicaid through one of the following methods:

- Contacting Provider Services at (800) 947-9627 or (608) 221-9883.
- Writing to Wisconsin Medicaid. To request a form, providers should include a return address, the name of the form, and the

HCF number of the form (HCF 11021, Rev. 06/04) and send the request to:

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

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. 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.

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 *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) Completion Instructions

(A copy of the "Prior Authorization Request/Hearing Instrument and Audiological Services [PA/HIAS2] Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID

PRIOR AUTHORIZATION REQUEST / HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2) COMPLETION INSTRUCTIONS

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) form is mandatory when requesting PA for hearing instruments. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is mandatory. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Providers are required to attach the completed Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) form to the PA/HIAS1 and physician prescription (if necessary) 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 — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the requesting hearing instrument specialist or audiologist.

Element 2 — Wisconsin Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the requesting hearing instrument specialist or audiologist.

Element 3 —Telephone Number — Provider
Enter the telephone number, including area code, of the requesting hearing instrument specialist or audiologist.

Element 4 — Address — Provider
Enter the complete address of the requesting hearing instrument specialist or audiologist (including street, city, state, and Zip code).

SECTION II — RECIPIENT INFORMATION

Element 5 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 7 — Telephone Number — Recipient
Enter the recipient's telephone number, including the area code.

Element 8 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Wisconsin Medicaid identification number.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to indicate male or female.

Element 10 — Has the Recipient Ever Used a Hearing Instrument?
Enter an "X" in the appropriate box.

Element 11 — Describe Prior Hearing Instrument Use
Describe the recipient's prior hearing instrument use.

Element 12 — Testing Date
Enter the date, in MM/DD/YYYY format, of the audiological testing/evaluation.

Element 13 — Test Reliability
Circle the proper reliability of the test.

SECTION III — DOCUMENTATION

Elements 14-16
Document all audiological testing and results.

Element 17 — Recommendations for a Hearing Instrument
Describe recommendations for a hearing instrument.

Element 18 — Signature — Requesting Provider
The signature of the requesting hearing instrument specialist or audiologist is required in this element.

Element 19 — Name — Requesting Provider
Print the requesting hearing instrument specialist or audiologist's name.

Element 20 — Provider Type
Indicate if the provider is a hearing instrument specialist or an audiologist.

Element 21 — Date Signed
Enter the date the provider signed the request.

ATTACHMENT 2
Sample Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) Form

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11021 (Rev. 06/04)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST / HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2)

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 PA/HIAS2 Completion Instructions (HCF 11021A).

SECTION I — PROVIDER INFORMATION

1. Name — Provider	4. Address — Provider (Street, City, State, Zip Code)
2. Wisconsin Medicaid Provider Number	
3. Telephone Number — Provider	

SECTION II — RECIPIENT INFORMATION

5. Name — Recipient (Last, First, Middle Initial)	6. Date of Birth — Recipient	7. Telephone Number — Recipient
8. Recipient Medicaid Identification Number	9. Sex — Recipient ❑ Male ❑ Female	10. Has the Recipient Ever Used a Hearing Instrument? ❑ Yes ❑ No
11. Describe Prior Hearing Instrument Use	12. Testing Date	13. Test Reliability (check one) ❑ Good ❑ Fair ❑ Poor

SECTION III — DOCUMENTATION

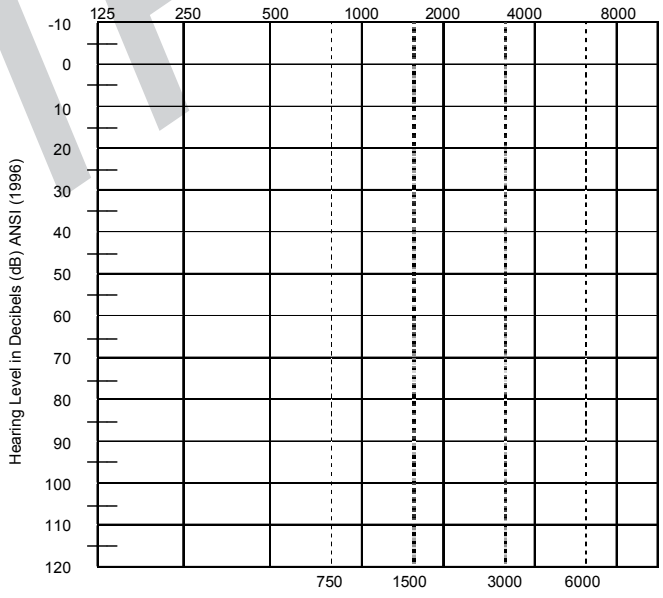
14.

Legend

Ear	Air: Un masked	Air: Masked	Bone: Un masked	Bone: Masked	NR
Right	o - o	Δ – Δ	<	[	↙
Left	x - x	■ –	>	]	↘

SPEECH AUDIOMETRY	R	L	SF
Threshold (SRT or SDT)			
Word recognition in quiet			
Word recognition in noise			
Uncomfortable level (dB-HL)			
Most comfortable level (dB-HL)			

15. Pure Tone Audiogram — Frequency in Hertz (Hz)



16. Additional Audiometric Studies and Results, Pertinent Social Background, Other Relevant Information (use an attachment if necessary)

17. Recommendations for a Hearing Instrument (use an attachment if necessary)

Ear (check one) ❑ Left ❑ Right ❑ Both

Ear Mold Style_____ Hearing Aid Style_____

Describe Electroacoustic Specifications

Ear Mold ❑ Left ❑ Right ❑ Both

Special Modifications

18. **SIGNATURE** — Requesting Provider	19. Name — Requesting Provider (Print)	20. Provider Type (check one): ❑ Audiologist ❑ Hearing Instrument Specialist	21. Date Signed