wisconsin Medicaid update
and BadgerCare

June 2004 ● No. 2004-50

Wisconsin Medicaid and BadgerCare Information for Providers

To:

- Home Health Agencies
- Hospice Providers
- Individual Medical Supply Providers
- Medical Equipment Vendors
- Nursing Homes
- Pharmacies
- Rehabilitation Agencies
- HMOs and Other Managed Care Programs

Introducing the Prior Authorization/Oxygen Attachment

Wisconsin Medicaid is introducing the Prior Authorization/Oxygen Attachment (PA/OA). Effective for paper PA requests received by Wisconsin Medicaid on and after September 1, 2004, providers of oxygen-related services are required to use the PA/OA instead of the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA).

New Prior Authorization/Oxygen Attachment

Wisconsin Medicaid is introducing the Prior Authorization/Oxygen Attachment (PA/OA). Effective for new or initial paper PA requests received by Wisconsin Medicaid on and after September 1, 2004, providers of oxygen-related services are required to use the PA/OA instead of the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA). Prior authorization requests for oxygen-related services received on the PA/DMEA will be returned. Providers are encouraged to begin using the PA/OA immediately.

Providers are required to submit both the Prior Authorization Request Form (PA/RF) and the PA/OA for oxygen-related services only, including stationary and portable oxygen systems, oxygen contents, and oxygen concentrators. For all other durable medical equipment, providers are required to submit a separate PA request including both the PA/RF and the PA/DMEA.

Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a copy of the completion instructions for the new PA/OA. Attachment 2 is a copy of the PA/OA, HCF 11066 (06/04), for providers to photocopy.

Returned Prior Authorization Requests

Prior authorization requests for oxygen-related services submitted with the PA/DMEA that are received by Wisconsin Medicaid before September 1, 2004, and returned to the provider for more information, may be resubmitted with the PA/DMEA, even after September 1, 2004. Providers will not have to convert information from the PA/DMEA to the PA/OA.

Recipients Residing in Nursing Homes

When completing a PA request for a recipient who resides in a nursing home, a Record of Actual Daily Oxygen Use form or a copy of the nursing home's record of the recipient's oxygen use must be submitted with the PA/RF and PA/OA. Refer to Attachment 3 for a copy of the Record of Actual Daily Oxygen Use form, HCF 11067 (06/04).

Obtaining Paper Copies of Forms

The PA/OA and Record of Actual Daily Oxygen Use form are available in fillable Portable Document Format (PDF) on the

forms page of the Medicaid Web site. To access this page:

- Go to *dhfs.wisconsin.gov/medicaid/*.
- Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
- Choose "Provider Forms" from the "Provider Publications and Forms" topic area.
- Scroll down the page and find the appropriate form.
- Click on either the fillable PDF version or the fillable Microsoft® Word format of the form.

All forms on the "Provider Forms" page are available as fillable PDFs and can be viewed with Adobe Acrobat Reader®.[1] The fillable PDF version allows providers to complete the form on their computer using Adobe Acrobat Reader® and then print it. To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Click on the dash-outlined boxes with the cursor to enter information in each field. Press the "Tab" key to move from field to field.

Selected Medicaid forms are also available in fillable Microsoft® Word format on the Medicaid Web site. The fillable Microsoft® Word format allows providers to complete the form on their computer using Microsoft® Word and then print it. To complete a fillable Microsoft® Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.[2]
- Click on the grey boxes with the cursor to enter information in each field. Press the "Tab" key to move from field to field.

Submitting Prior Authorization Requests

Providers may submit PA requests by fax, mail, or via the Medicaid PA Web site.

Submitting Paper Prior Authorization Requests

Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616; or, by mail to:

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

Providers may submit PA requests by fax, mail, or via the Medicaid PA Web site.

Submitting Prior Authorization Requests Via the Medicaid Web Site

Effective July 12, 2004, Wisconsin Medicaid will accept PA requests via the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for oxygen-related services. Refer to the June 2004 *Update* (2004-53), titled "Submitting Prior Authorization Requests Via the Web for Selected Services," for more information. Providers are not required to submit PA requests for oxygen-related services via the Medicaid Web site and may continue to submit PA requests for oxygen-related services on paper by mail or fax.

Providers submitting PA requests via the Medicaid PA Web site are required to complete the Record of Actual Daily Oxygen Use screen in lieu of attaching the nursing home's oxygen use records for those recipients who reside in a nursing facility. Information on this form must match the information in the recipient's medical record.

For More Information

For questions about the PA/OA, Record of Actual Daily Oxygen Use form, or to request paper copies, call Provider Services at (800) 947-9627 or (608) 221-9883.

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.

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[1]The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat® is obtained, providers may save completed PDFs to their computer. Refer to the Adobe® Web site, *www.adobe.com/,* for more information about fillable PDFs.

[2]Providers may save fillable Microsoft® Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

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/*.

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ATTACHMENT 1
Prior Authorization/Oxygen Attachment (PA/OA) Completion Instructions

(A copy of the "Prior Authorization/Oxygen Attachment [PA/OA] Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA) COMPLETION INSTRUCTIONS

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services. The use of this form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

INSTRUCTIONS: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested oxygen-related equipment or supplies. All oxygen-related services must be prescribed by a physician prior to providing the service. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Providers may attach a photocopy of the physician's prescription to the completed Prior Authorization/Oxygen Attachment (PA/OA) or the prescribing physician may sign and date the PA/OA in lieu of attaching the prescription. The prescription (or PA/OA) must be signed and dated within 30 days prior to receipt by Wisconsin Medicaid. Attach the PA/OA to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers are required to attach a completed Record of Actual Daily Oxygen Use form (HCF 11067) or a copy of the recipient's oxygen use records to the PA/OA for recipients who reside in a nursing home.

Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616; or, by mail to the following address:

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

The provision of services which 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 — Medical Equipment Vendor
Enter the name of the medical equipment vendor (oxygen provider).

Element 2 — Medical Equipment Vendor's Medicaid Provider No.
Enter the eight-digit Medicaid provider number of the medical equipment vendor (oxygen provider). The provider number in this element must correspond with the provider name listed in Element 1.

Element 3 — Telephone Number — Medical Equipment Vendor
Enter the medical equipment vendor's telephone number, including area code.

Element 4 — Requested Start Date
Enter the requested grant date for this PA request in MM/DD/CCYY format.

Element 5 — Name — Person Completing Form
Enter the name of the person completing this form if other than the treating physician.

Element 6 —Title — Person Completing Form
Enter the title of the person completing this form if other than the treating physician (e.g., respiratory therapist, home health nurse, billing manager).

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 8 — Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number
Enter the eight-digit Medicaid provider number or the six-character Universal Provider Identification Number (UPIN) of the prescribing physician. The provider number or UPIN in this element must correspond with the provider name listed in Element 7.

Element 9 — Address — Prescribing Physician
Enter the complete address (street, city, state, and Zip code) of the prescribing physician.

Element 10 — Telephone Number — Prescribing Physician
Enter the prescribing physician's telephone number, including area code.

SECTION II — RECIPIENT INFORMATION

Element 11 — Name — Recipient (Last, First, Middle Initial)
Enter the recipient's last name, followed by his or her first name and middle initial.

Element 12 — Recipient Medicaid Identification 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 to obtain the correct identification number.

Element 13 — Height and Weight — Recipient
Enter the recipient's height in inches and weight in pounds. This field is optional unless height and weight are related to respiratory diagnosis.

Element 14 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/CCYY format (e.g., February 10, 1927, would be 02/10/1927).

Element 15 — Place of Service
Select the appropriate place of service (POS) code. If POS code "31" (Skilled nursing facility) or "32" (nursing facility) are selected, complete Element 16.

Element 16 — Name and Address — Facility (if applicable)
Enter the name and address of the nursing facility in which the recipient resides, if applicable.

SECTION III — CLINICAL INFORMATION

Element 17 — Estimated Length of Need
Enter the estimated time (in months) the recipient will require oxygen. If the physician expects that the recipient will require the item for the duration of his or her life, then enter "99."

Element 18 — Diagnosis — Codes and Descriptions
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis codes and descriptions most relevant to the oxygen-related services requested.

Note: Medical equipment vendors may provide only a written description.

Element 19 — Qualifying Test
Enter the results of the qualifying test taken within 60 days prior to the date of submission or requested start date of the PA request. The criteria for coverage of oxygen-related services include one or both of the following:

- Oxygen saturation level (SAO_2) of 88 percent or lower.
- Arterial blood gas level (PO_2) of 55 mm/Hg or lower.

Test results must have been taken within 60 days prior to the date of submission or the requested start date. Test results are to be available in the recipient's record or case file.

Element 20
Enter the oxygen liter flow rate/number of hours per day ordered by a physician. If not used on a scheduled basis, describe circumstances and frequency of use.

Element 21 — Type of Oxygen Prescribed
Indicate the type of oxygen requested.

Element 22 — Means of Delivery Prescribed
Indicate the means of delivery of the oxygen.

Element 23
Answer questions a-c about portable oxygen and recipient mobility information.

Element 24
If the recipient's arterial blood gas level (PO_2) is 56 mm/Hg or above or the recipient's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

Element 25
Describe the medical condition of the recipient that supports the use of oxygen (e.g., describe why the recipient needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

Element 26 — Date of Prescription
Enter the date of the physician's prescription in MM/DD/CCYY format.

Element 27 — Prescription as Written
Indicate a description of the physician's prescription as it is written.

Element 28 — SIGNATURE — Prescribing Physician
The original signature of the provider prescribing the oxygen-related services must appear in this element or the physician's prescription must be attached to the PA request.

Element 29 — Date Signed
Enter the month, day, and year the PA/OA was signed in MM/DD/CCYY format.

If the prescribing physician signs the PA/OA, Wisconsin Medicaid will accept it in lieu of the physician's written prescription and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician before oxygen is administered and within 30 days prior to the date of submission or the requested start date of the PA request.

ATTACHMENT 2
Prior Authorization/Oxygen Attachment (PA/OA)

(A copy of the "Prior Authorization/Oxygen Attachment [PA/OA]" is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA)

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/Oxygen Attachment (PA/OA) Completion Instructions (HCF 11066A). Providers are required to attach a completed Record of Actual Daily Oxygen Use form (HCF 11067) or a copy of the recipient's oxygen use records to the PA/OA for recipients who reside in a nursing home.

SECTION I — PROVIDER INFORMATION

1. Name — Medical Equipment Vendor
2. Medical Equipment Vendor's Medicaid Provider No.
3. Telephone Number — Medical Equipment Vendor
4. Requested Start Date
5. Name — Person Completing Form
6. Title — Person Completing Form
7. Name — Prescribing Physician
8. Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number
9. Address — Prescribing Physician
10. Telephone Number — Prescribing Physician

SECTION II — RECIPIENT INFORMATION

11. Name — Recipient (Last, First, Middle Initial)
12. Recipient Medicaid Identification Number
13. Height and Weight — Recipient

    Height _____ inches Weight _____ lbs
14. Date of Birth — Recipient
15. Place of Service (choose one)
    - ❑ 11 = Office
    - ❑ 12 = Home
    - ❑ 31 = Skilled Nursing Facility
    - ❑ 32 = Nursing Facility
    - ❑ 99 = Other Place of Service
16. Name and Address — Facility (if applicable)

SECTION III — CLINICAL INFORMATION

17. Estimated Length of Need (1-98 months; 99 = Lifetime)

    _____ months
18. Diagnosis — Codes and Descriptions

    Primary —

    Secondary —
19. Qualifying Test — Enter results of test taken within 60 days prior to the date of submission or requested start date of the PA request. Test results are to be available in the recipient's record or case file. **Note: Criteria for coverage of oxygen-related services include either an oxygen saturation level (SAO_2) of 88 percent or lower or an arterial blood gas level (PO_2) of 55 mm/Hg or lower.**

    a) Date ____/____/_____ (MM/DD/CCYY)

    b) Recipient condition during test (choose one)

    ❑ At rest ❑ During exercise ❑ During sleep

    c) Arterial blood gas level (PO_2) _____ mm/Hg

    d) Oxygen saturation level (SAO_2) _____ %

    e) Name and Address — Provider Performing Qualifying Test

(Continued)

SECTION III — CLINICAL INFORMATION (cont.)

20. Enter the oxygen liter flow rate / number of hours per day as prescribed by the physician.

a) _____ Liters per minute

b) _____ Hours per day

c) _____ Days per week

d) _____ Continuous

e) _____ PRN, describe circumstances and frequency of use —

21. Type of Oxygen Prescribed
- ❑ Concentrator
- ❑ Liquid
- ❑ Gaseous

22. Means of Delivery Prescribed
- ❑ Nasal Cannula
- ❑ Mask
- ❑ Other (Specify) _____

23. Indicate portable oxygen and recipient mobility information, if applicable.

a) Is portable oxygen prescribed? ❑ Yes ❑ No ❑ N/A

b) If portable oxygen is prescribed, is the recipient mobile? ❑ Yes ❑ No ❑ N/A

c) If the recipient is mobile and portable oxygen is prescribed, describe to what extent the recipient is mobile.

24. If the recipient's arterial blood gas level (PO_2) is 56 mm/Hg or above or the recipient's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

a) Does recipient have clinical evidence of chronic or recurrent congestive heart failure? ❑ Yes ❑ No ❑ N/A

b) Does recipient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an electrocardiogram or by an echocardiogram, gated blood pool scan, or direct pulmonary artery pressure measurement? ❑ Yes ❑ No ❑ N/A

c) Does recipient have clinical evidence of decubital angina? ❑ Yes ❑ No ❑ N/A

d) Does recipient have erythrocythemia with a hematocrit greater than 56 percent? ❑ Yes ❑ No ❑ N/A

25. Describe the medical condition of the recipient that supports the use of oxygen (e.g., describe why the recipient needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

26. Date of Prescription (MM/DD/CCYY)

27. Prescription as Written

If the prescribing physician signs the PA/OA, Wisconsin Medicaid will accept it in lieu of the physician's written prescription and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated before oxygen is administered. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of submission or the requested start date of the PA request.

28. **SIGNATURE** — Prescribing Physician

29. Date Signed

Reset Form

ATTACHMENT 3
Record of Actual Daily Oxygen Use

(A copy of the "Record of Actual Daily Oxygen Use" form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11067 (06/04)

WISCONSIN MEDICAID
RECORD OF ACTUAL DAILY OXYGEN USE

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services. The use of this form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

INSTRUCTIONS: Attach this completed form to the Prior Authorization/Oxygen Attachment (PA/OA) when submitting PA requests for recipients residing in a nursing facility. In Section III, place an "X" in each shift for each day that the recipient actually received oxygen for at least the first 15 days of a 30-day rental. The oxygen need not be administered for the whole shift. Leave blank any shifts when oxygen was not administered. Providers may submit a completed copy of this form or a copy of the nursing home's oxygen use records with paper or faxed PA requests. Information on this form must match the recipient's medical records exactly. A new form should be completed for each new PA request for oxygen-related services.

SECTION I — PROVIDER INFORMATION

Name — Prescribing Physician	Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number

SECTION II — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number

SECTION III — RECORD OF DAILY USE

Complete the date oxygen was initiated in MM/DD/CCYY format. This date is "Day 1." _____ / _____ / _____

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
AM							
PM							
NOC							
	DAY 8	DAY 9	DAY 10	DAY 11	DAY 12	DAY 13	DAY 14
AM							
PM							
NOC							
	DAY 15	DAY 16	DAY 17	DAY 18	DAY 19	DAY 20	DAY 21
AM							
PM							
NOC							
	DAY 22	DAY 23	DAY 24	DAY 25	DAY 26	DAY 27	DAY 28
AM							
PM							
NOC							
	DAY 29	DAY 30	DAY 31				
AM							
PM							
NOC							

Reset Form