wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Home Health Agencies

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 *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

Revision to Prior Authorization/Enteral Nutrition Product Attachment Completion Instructions

Wisconsin Medicaid is revising Element 13 of the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions, HCF 11054A (Rev. 07/04).

Revision of Instructions

Wisconsin Medicaid is revising Element 13 of the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions, HCF 11054A (Rev. 07/04), which were published in the August 2003 *Wisconsin Medicaid and BadgerCare Update* (2003-99), titled "Changes to paper claims and prior authorization for enteral nutrition products as a result of HIPAA." The revised instructions are for Element 13 — Drug Enforcement Administration Number:

> Enter the Drug Enforcement Administration (DEA) number. If the provider is unable to obtain a prescriber's current DEA number after a reasonable effort, the provider may use the appropriate default DEA number:
>
> - XX5555555 — Prescriber's DEA number cannot be obtained.
> - XX9999991 — Prescriber does not have a DEA number.
>
> Default DEA numbers may be indicated for prescriptions for enteral nutrition products; however, default DEA numbers must not be used for prescriptions for controlled substances.

Refer to Attachments 1 and 2 of this *Update* for the revised completion instructions and a copy of the PA/ENPA, HCF 11054 (Rev. 07/03). The form is attached for providers' convenience.

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.

ATTACHMENT 1

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

(A copy of the "Prior Authorization/Enteral Nutrition Product [PA/ENPA] Completion Instructions" 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 11054A (Rev. 07/04)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA) 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. 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 in this form 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 judgment 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, 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 product.

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 (DEA) number. If the provider is unable to obtain a prescriber's current DEA number after a reasonable effort, the provider may use the appropriate default DEA number:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

Default DEA numbers may be indicated for prescriptions for enteral nutrition products; however, default DEA numbers 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 the weight was lost.

Element 21
Check all that apply.

Element 22 — Signature — Pharmacist or Dispensing Physician
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 2

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. Providers who wish to submit PA requests by mail may do so by submitting them 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 product, for this recipient, by this provider.
- ❑ This is a request to renew or extend previously approved PA for therapy using this product.

  First PA number_____

- ❑ This is a request to change or add a new Healthcare Common Procedure Coding System (HCPCS) procedure code to a current valid PA.

  First PA number_____ HCPCS 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 food, 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 (WIC) program.

22. **SIGNATURE** — Pharmacist or Dispensing Physician	23. Date Signed

24. Please notify the provider of approval / denial by:

- ❑ Fax (include Fax number) _____
- ❑ Telephone (include telephone number) _____
- ❑ No special notice needed.