wisconsin Medicaid update and BadgerCare

May 2005 ● No. 2005-26

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 Revised Prior Authorization/ Oxygen Attachment and Clarifying Medicaid Coverage of Oxygen Services

This *Wisconsin Medicaid and BadgerCare Update* introduces the revised Prior Authorization/Oxygen Attachment (PA/OA), HCF 11066 (Rev. 05/05), and completion instructions and clarifies Medicaid coverage of oxygen services. This *Update* replaces the June 2004 *Update* (2004-50), titled "Introducing the Prior Authorization/Oxygen Attachment."

This *Wisconsin Medicaid and BadgerCare Update* introduces the revised Prior Authorization/Oxygen Attachment (PA/OA), HCF 11066 (Rev. 05/05), and completion instructions, HCF 11066A (Rev. 05/05), and clarifies Medicaid coverage of oxygen services. This *Update* replaces the June 2004 *Update* (2004-50), titled "Introducing the Prior Authorization/Oxygen Attachment."

Revised Prior Authorization Forms for Oxygen Services

Wisconsin Medicaid has revised the PA/OA and completion instructions. Now providers are *required* to include in Element 19e the credentials, in addition to the name and address, of the provider performing the qualifying test. Prior authorization requests without the credentials of the provider performing the qualifying test in Element 19e will be returned. The signature instructions have also been revised.

The new PA/OA, which may be photocopied for future use, is included as Attachment 2 of this *Update*. Attachment 1 includes the completion instructions.

Wisconsin Medicaid has also revised the instructions for the Record of Actual Daily Oxygen Use form, HCF 11067 (Rev. 05/05). Providers are reminded that this form must be submitted with the Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 06/03), and PA/OA when completing a PA request for a recipient who resides in a nursing home. The new Record of Actual Daily Oxygen Use form, which may be photocopied for future use, is included in Attachment 3.

Providers should begin using the revised PA/OA and Record of Actual Daily Oxygen Use forms as soon as feasible.

Obtaining Forms

The PA/OA and Record of Actual Daily Oxygen Use forms are available in fillable Portable Document Format (PDF) from the Forms page of the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. The fillable PDF may be accessed using Adobe Reader®* and may be completed electronically by selecting the dash-outlined boxes to enter information. Press the "Tab" key to move from

one box to the next. Providers may then print the form and send it to Wisconsin Medicaid.

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

In addition, forms are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, the form number, and the quantity being requested and send the request to:

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

Submitting Prior Authorization Requests

Providers are required to submit both the PA/RF and the PA/OA for oxygen-related services, including stationary and portable oxygen systems, oxygen contents, and oxygen concentrators. Prior authorization requests for recipients who reside in nursing homes must include a Record of Actual Daily Oxygen Use form along with the PA/RF and PA/OA. Providers may also be required to submit additional supporting documentation, when applicable.

Providers have the following options for submitting PA requests:

- By mail to the address on the form.
- By fax to (608) 221-8616.
- Via the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. Refer to the January 2005 *Update* (2005-09), titled "Additional Option for Submitting Prior Authorization Requests Via the Web," for more information.

Prior Authorization/Oxygen Attachment Reminders

The following are reminders about the PA/OA:

- Element 13 is optional unless the height and weight of the recipient are related to the respiratory diagnosis.
- Element 18 requires providers to demonstrate the medical necessity of oxygen by indicating the diagnosis code *and* the specific description of the respiratory diagnosis that accurately describes the recipient's condition. Past experience has shown a high likelihood of providers indicating an incorrect diagnosis code related to oxygen use when only the diagnosis code is indicated in Element 18.
- Element 25 is used to explain the individual's conditions or symptoms and the need for oxygen that are not answered in other elements of the PA request. Examples include, but are not limited to, seizures and convulsions. Providers may also use Element 25 of the PA/OA to explain special needs of children receiving oxygen.

  A description of the recipient's medical condition is not necessary in Element 25 if the information is already provided elsewhere on the PA/OA. For example, it would not be necessary to indicate in this element that a recipient has a chronic condition such as a diagnosis of congestive heart failure and has an oxygen saturation level of 85 percent at rest, since that information would already be indicated in Elements 18 and 19.

Reminders About Oxygen Services

Providers are reminded that reimbursement for oxygen services can be made only for the days the recipient actually uses it, whether the recipient is using oxygen in his or her home or in a nursing facility.

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Prescriptions for Oxygen Services

The Food and Drug Administration identifies oxygen as a legend drug, and prescriptions are required for legend drugs. Therefore, providers are required to have a physician's prescription *before* administering oxygen. Verbal orders for oxygen services are acceptable for initiating the administration of oxygen when the following requirements are met:

- The verbal orders are given to a licensed or certified individual of the nursing home or the home care services provider.
- The verbal orders are followed up with a signed and dated physician's written prescription within 10 days, whether the recipient resides in a nursing home or receives home care services.

Providers may attach a photocopy of the physician's prescription to the completed 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 the date of receipt by Wisconsin Medicaid or the requested start date of the PA request. Attach the PA/OA to the PA/RF and send it to Wisconsin Medicaid. Standing orders are not acceptable.

Providers are required to review the medical necessity of any service provided to a recipient on an ongoing basis.

A physician's prescription for oxygen services should indicate a specific liter flow; however, a range (e.g., O_2 @ 2-4 liters per minute) is acceptable if the prescription also indicates that a certain blood saturation level must be maintained during unstable periods. When the prescription indicates a range, and not a specific liter flow, Wisconsin Medicaid requires that the following be documented in the recipient's file:

- Frequent monitoring of oxygen saturation levels.
- Varying liter flow.

Medical Necessity

Whether a recipient resides in a skilled nursing facility (SNF) or at home, providers are required to establish medical necessity *before* oxygen services are provided. (For recipients in SNFs, medical necessity needs to be established *before* the recipient receives oxygen whether it is to be administered at the time of admission or later during the recipient's stay.) Providers are required to review the medical necessity of any service provided to a recipient on an ongoing basis.

Oxygen Saturation Levels

Medical necessity is established by the measurement of arterial oxygen saturation by arterial blood gas studies or pulse oximetry. Providers should keep the following in mind when obtaining oxygen saturation level readings:

- Room air oxygen saturation levels should be taken when the recipient is in a stable, chronic state. Documentation must indicate the specific oxygen saturation level at the time the level was taken; ranges are not acceptable.
- If a recipient's condition dictates, it is acceptable to perform an oxygen saturation level while the recipient is receiving oxygen if the recipient's blood oxygen saturation level is equal to or less than 88 percent (on oxygen). Providers are required to note in Element 25 of the PA/OA that the recipient was on oxygen at the time the test was taken. The performing provider is required to provide documentation in the recipient's medical record that supports the information given in Element 25 of the PA/OA and the medical necessity for oxygen services.
- Room air oxygen saturation level readings must be performed any time the recipient's medical condition changes resulting in an oxygen usage change. In addition, Wisconsin Medicaid may request that

oxygen saturation levels be indicated on PA request renewals to ensure medical necessity for continued need for oxygen services.

Documenting Representative

Wisconsin Medicaid does not specify the credentials of the documenting representative, but the documenting representative is required to have direct knowledge or factual information of the oxygen use they are documenting for the recipient. Additional information may be requested concerning the source of oxygen use documentation. (Skilled nursing facilities should follow their policies, which must comply with Wisconsin nursing home rules and regulations.)

Pulse Oximetry Readings

A pulse oximetry reading is acceptable when ordered and evaluated by the attending physician and performed under his or her supervision or when performed by a qualified provider or a supplier of laboratory services. The provider of the oxygen services or its entities may not perform these readings.

Portable Oxygen Equipment

Documentation and medical necessity requirements apply to all types of oxygen services, including portable oxygen. The extent of the recipient's mobility and need for portable oxygen must be documented in the recipient's medical record.

Changes to Oxygen Liter Flow

Prior authorization request approval is based on *average* liter flow. If the liter flow increases or decreases on a temporary basis, providers should make no changes to the PA request. If the liter flow increases or decreases for an extended period of time, providers may amend the PA request to reflect the change. Refer to the Forms page of the Medicaid Web site for a Prior Authorization Amendment Request, HCF 11042 (Rev. 06/03).

Documentation of Oxygen Services in a Recipient's Home

When a drug (oxygen) is prescribed for self-administration in the recipient's home, daily documentation is not feasible. However, documentation of hours of concentrator use and maintenance of equipment are required to show the level of service that is provided in the recipient's home.

Record of Actual Daily Oxygen Use Form

If a recipient is in an SNF, the PA request must include a record of the actual daily usage of oxygen for at least the first 15 days of the initial 30-day rental period. A provider should submit a PA request for a recipient in a nursing home even if the recipient does not use oxygen for 15 *consecutive* days within the 30-day period but uses it a minimum of 15 days within the 30-day period. The provider should explain the situation on the PA request. Wisconsin Medicaid will consider these PA requests on a case-by-case basis.

When requesting PA, nursing homes are required to indicate with an "X" on the Record of Actual Daily Oxygen Use form each shift that a recipient uses oxygen or submit a copy of the nursing home's record of the recipient's oxygen use. Documentation of medication administration is required during every shift for prescription drugs (e.g., oxygen) administered in a nursing home by nursing home staff.

When requesting PA, nursing homes are required to indicate with an "X" on the Record of Actual Daily Oxygen Use form each shift that a recipient uses oxygen or submit a copy of the nursing home's record of the recipient's oxygen use.

Signatures

Providers are required to keep a copy of the physician's signed and dated PA/OA *or* the physician's signed and dated prescription in the recipient's file. As a reminder, the written copy must match what is stated in the PA request.

Web PA users must type in the name of the person who is required to sign the forms for the elements that need a signature. Providers may print a copy of the forms submitted via the Web and have them signed for their own records. Refer to the Medicaid Web site for more information about submitting Web PA requests.

For More Information

Providers may refer to HFS 106.02(9)(a), Wis. Admin. Code, and the Provider Rights and Responsibilities section of the All-Provider Handbook for more information on documentation and record retention and maintenance.

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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*The Medicaid Web site provides instructions on how to obtain Adobe Reader® at no charge from the Adobe® Web site. Adobe 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.

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/Oxygen Attachment (PA/OA) Completion Instructions (for photocopying)

(A copy of the "Prior Authorization/Oxygen Attachment [PA/OA] Completion Instructions" [for photocopying] 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), HCF 11066, 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), HCF 11018, 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 to Wisconsin Medicaid by fax 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 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 — 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
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) that 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* diagnosis codes and descriptions most relevant to the oxygen-related services requested.

Note: Medical equipment vendors may choose to 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
Enter the physician's prescription as it is 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 by the physician within 30 days prior to the date of receipt by Wisconsin Medicaid or the requested start date of the PA request.

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.

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

(A copy of the "Prior Authorization/Oxygen Attachment [PA/OA]" [for photocopying] 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 (Street, City, State, and Zip Code)	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, Address, and Credentials — 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	22. Means of Delivery Prescribed
❑ Concentrator	❑ Nasal Cannula
❑ Liquid	❑ Mask
❑ Gaseous	❑ 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 by the physician within 30 days prior to the date of receipt by Wisconsin Medicaid or the requested start date of the PA request.

28. **SIGNATURE** — Prescribing Physician	29. Date Signed

ATTACHMENT 3
Record of Actual Daily Oxygen Use (for photocopying)

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11067 (Rev. 05/05)

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), HCF 11066, 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. The recipient must receive oxygen for at least 15 days of a 30-day rental period for a PA request to be considered for approval. 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							