wisconsin Medicaid update
and BadgerCare
September 2005 ● No. 2005-57
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Home Health Agencies
Nurse Practitioners
Nurses in Independent Practice
HMOs and Other Managed Care Programs

Wisconsin Medicaid Issues Prior Authorization Home Care Attachment for Home Health and Private Duty Nursing Services

Wisconsin Medicaid has issued a new attachment that providers may begin using immediately as the recipient's plan of care (POC) when requesting prior authorization (PA) for home care services. The form is the Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096 (Dated 09/05). Providers may also choose to submit the recipient's POC in another format containing *all* of the components requested in the Prior Authorization/ Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A (Dated 09/05).

Also, effective immediately, providers of private duty nursing for ventilator-dependent recipients are no longer required to submit the Respiratory Care Services/Plan of Care (RCS/POC), HCF 11043, with PA requests in addition to the POC.

Prior Authorization/Home Care Attachment Available

Wisconsin Medicaid has issued a new attachment that providers may begin using as the recipient's plan of care (POC) when requesting prior authorization (PA) of home care services, titled Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096 (Dated 09/05). Providers may begin using the PA/HCA immediately or submit the recipient's POC in another format containing *all* of the components requested in the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A (Dated 09/05). All components requested for PA must be incorporated no later than December 1, 2005.

When completed according to the PA/HCA Completion Instructions, the PA/HCA contains the information Wisconsin Medicaid requires to adjudicate a provider's PA request for home care services. Incomplete PA requests will be returned to the provider.

The Bureau of Quality Assurance (BQA) in the Division of Disability and Elder Services has reviewed the PA/HCA. The BQA indicates that all the Medicare POC requirements as of July 1, 2005, are listed in the instructions of this Wisconsin Medicaid form.

Submitting Another Format for the Recipient's Plan of Care

Providers who choose to submit the recipient's POC in another format are required to include all of the components requested in the PA/HCA Completion Instructions. Prior authorization requests received without the requested information will be returned to the provider.

Providers choosing this option should note that the nurse and physician who sign the POC are required to certify to the respective Wisconsin Medicaid certification statements in Section VI of the PA/HCA Completion Instructions.

To speed processing and reduce the number of returned PA requests, providers are strongly encouraged to verify that all requested information is included with the PA request when choosing to submit a version of the POC other than the PA/HCA.

Home Care Services Prior Authorization Attachment Submission

Providers are required to submit the PA/HCA or another format of the recipient's POC with all PA requests when requesting the following home care services:

- Home health skilled nursing.
- Home health aide.
- Private duty nursing (PDN), including PDN for ventilator-dependent recipients.

Note: Personal care providers are not required to submit the PA/HCA for personal care services. Providers requesting PA for personal care services should continue to follow instructions for submitting PA requests as stated in personal care publications.

Most of the elements of the PA/HCA are required for all providers; however, the PA/HCA Completion Instructions indicate where information is requested from only specific provider types. Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a complete listing of all PA forms that must be submitted to Wisconsin Medicaid for each type of home care service.

Services Included in the Plan of Care Certification Dates

The certification period of the POC includes both the "From" date and the "To" date listed on the POC. No certification period may exceed a total of 62 days. Requests for subsequent periods of recertification should begin with the day directly following the date listed as the "To" date in the immediately preceding certification period.

Note: Providers should count *all* of the days in the certification period. Remember to adjust for consecutive months with 31 days.

> *Example:*
> Initial Certification Period
> "From" date — 05/03/05
> *(plus 61 days)*
> "To" date — 07/03/05
> *(for a total of 62 days)*
>
> Subsequent Recertification Period
> "From" date — 07/04/05
> *(plus 61 days)*
> "To" date — 09/03/05
> *(for a total of 62 days)*

Obtaining the Prior Authorization/Home Care Attachment

Providers may obtain the PA/HCA by one of the following methods:

- Accessing the form 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®, completed electronically, and printed. To use a fillable PDF, select the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To speed processing and reduce the number of returned PA requests, providers are strongly encouraged to verify that all requested information is included with the PA request when choosing to submit a version of the POC other than the PA/HCA.

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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- Accessing the form in fillable Microsoft® Word format from the Forms page of the Wisconsin Medicaid Web site. A fillable Microsoft® Word document may be completed electronically and printed. The document may also be saved on a computer drive or on a disk.
- Photocopying the form from Attachment 3.
- Contacting Provider Services at (800) 947-9627 or (608) 221-9883, or 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 11096, Dated 09/05) and send the request to:

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

The PA/HCA Completion Instructions are available on the Medicaid Web site. Providers may also photocopy the completion instructions from Attachment 2.

Prior Authorization for Home Health Therapy Services

Home health providers requesting PA for therapy services should continue to use the Prior Authorization/Home Health Therapy Attachment (PA/HHTA), HCF 11044 (Rev. 06/03). Providers may obtain the PA/HHTA from the Forms page of the Wisconsin Medicaid Web site.

Separate Respiratory Care Services/ Plan of Care No Longer Required for Prior Authorization Requests

Effective immediately, providers of PDN for ventilator-dependent recipients are no longer required to submit the Respiratory Care Services/Plan of Care (RCS/POC), HCF 11043, with PA requests in addition to the POC.

Providers are now required to incorporate all information applicable to caring for ventilator-dependent recipients into the POC. Applicable information includes, but is not limited to:

- Ventilator settings and parameters.
- Procedures to follow in the event of accidental extubation.
- A plan for medical emergency.
- A plan to move the recipient to safety in the event of a condition that threatens the recipient's immediate environment.

Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment Revised

Because providers are no longer required to submit the RCS/POC, the Private Duty Nursing/Respiratory Care Services Prior Authorization Acknowledgment, HCF 11041 (Rev. 06/03), has also been updated to reflect this change. Effective immediately, the form will be referred to as the Private Duty Nursing Prior Authorization Acknowledgment, HCF 11041 (Rev. 09/05). Providers may continue to use this form for PDN recipients that are ventilator-dependent, as well as those who are not. Refer to Attachment 4 for a copy of the revised form.

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 Forms Required for Home Care Services

The following table contains a complete listing of the prior authorization (PA) forms required by Wisconsin Medicaid for each of the following types of home care services when providers are requesting PA for that service.

Home Care Service Type	Prior Authorization Forms Required by Wisconsin Medicaid
Home Health Skilled Nursing	• Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 10/03). • Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096 (Dated 09/05) **OR** another format of the recipient's plan of care (POC).
Home Health Aide	• PA/RF. • PA/HCA **OR** another format of the recipient's POC.
Private Duty Nursing	• PA/RF. • PA/HCA **OR** another format of the recipient's POC. • Private Duty Nursing Prior Authorization Acknowledgment, HCF 11041 (Rev. 09/05).
Private Duty Nursing for Ventilator-Dependent Recipients	• PA/RF. • PA/HCA **OR** another format of the recipient's POC. • Private Duty Nursing Prior Authorization Acknowledgment.
Home Health Therapy	• PA/RF. • Prior Authorization/Home Health Therapy Attachment (PA/HHTA), HCF 11044 (Rev. 06/03). • Therapy POC. • Therapy evaluation. • Individualized Family Service Plan (for children under 3 years of age). • Individualized Education Plan (for school-aged children between 3 and 21 years of age).
Personal Care	• Refer to personal care publications and follow instructions for submitting PA requests as stated.

ATTACHMENT 2
Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions

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

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA) 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 Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096, is a plan of care (POC) that may be completed for Wisconsin Medicaid recipients receiving home care services. The information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all the components requested on this form. If necessary, attach additional pages if more space is needed. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Retain the original, signed PA/HCA. Attach a copy of the PA/HCA to the Prior Authorization Request Form (PA/RF), HCF 11018, and submit it to Wisconsin Medicaid along with any attached additional information. 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 which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Prior Authorization Number
Enter the unique seven-digit number from the PA/RF. Enter the same PA number in the spaces provided at the top of each subsequent page of the form.

Element 2 — Name and Telephone Number — Recipient
Enter the name and telephone number, including the area code, of the recipient. If the recipient's telephone number is not available, enter "N/A."

Element 3 — Start of Care Date
Enter the date that covered services began for the recipient in MM/DD/YY format (e.g., March 13, 2005, would be 03/13/05). The start of care date is the date of the recipient's first billable home care visit. This date remains the same on subsequent POC until the recipient is discharged.

Element 4 — Certification Period
Enter the beginning and ending dates of the recipient's certification period respectively in the "From" and "To" portions of this element in the MM/DD/YY format. The certification period identifies the period of time approved by the attending physician for the POC.

The "To" date can be *up to*, but not more than, 62 days later than the "From" date. (Medicare certified agencies should use the timeframe of up to, but not more than *60 days* later.) For certification periods that cover consecutive 31-day months, providers should be careful not to exceed 62 days.

Services provided on the "To" date are included in the certification period. On subsequent periods of recertification, the certification period should begin with the day directly following the date listed as the "To" date in the immediately preceding certification period.

Example:

Initial Certification Period	
"From" date	12/01/04
"To" date	01/31/05

Subsequent Recertification Period	
"From" date	02/01/05
"To" date	04/03/05

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

Element 5 — Principal Diagnosis
Enter the principal diagnosis information. Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code, diagnosis code description, and the date of onset in MM/DD/YY format. If the recipient's condition is chronic or long-term in nature, use the date of exacerbation.

Element 6 — Surgical Procedure and Other Pertinent Diagnoses
Enter the surgical procedure information, if any, that is relevant to the care rendered or the services requested. Include the appropriate ICD-9-CM diagnosis code, diagnosis code description, and the date of the surgical procedure in MM/DD/YY format. The month and year of the date of the surgical procedure must be included. Use "00" if the exact day of the month is unknown (e.g., March 2005, would be 03/00/05).

Enter all other diagnoses pertinent to the care rendered for the recipient. Include the appropriate narrative or ICD-9-CM diagnosis code, code description, and the date of onset in MM/DD/YY format. Include all conditions that coexisted at the time the POC was established or that subsequently developed. Exclude conditions that relate to an earlier episode not associated with this POC. Other pertinent diagnoses in this element may be changed to reflect changes in the recipient's condition.

If a relevant surgical procedure was not performed and there are no other pertinent diagnoses, enter "N/A" (do not leave the element blank).

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

Element 7 — Durable Medical Equipment
Identify the item(s) of durable medical equipment (DME) ordered by the attending physician and currently used by the recipient. Enter "N/A" if no known DME has been ordered.

Element 8a — Functional Limitations
Enter an "X" next to all items that describe the recipient's current limitations as assessed by the attending physician and the nurse or therapist. If "Other" is checked, provide further explanation in Element 8b.

Element 8b
If "Other" is checked in Element 8a, specify the other functional limitations.

Element 9a — Activities Permitted
Enter an "X" next to all activities that the attending physician permits and/or that are documented in the attending physician's orders. If "Other" is checked, provide further explanation in Element 9b.

Element 9b
If "Other" is checked in Element 9a, specify the other activities the recipient is permitted.

Element 10 — Medications
Enter the attending physician's orders for all of the recipient's medications, including the dosage, frequency, and route of administration for each. If any of the recipient's medications cause severe side effects or reactions that necessitate the presence of a nurse, therapist, home health aide, or personal care worker, indicate the details of these circumstances in this element.

Element 11 — Allergies
List any medications or other substances to which the recipient is allergic (e.g., adhesive tape, iodine, specific types of food). If the recipient has no known allergies, indicate "no known allergies."

Element 12 — Nutritional Requirements
Enter the attending physician's instructions for the recipient's diet. Include specific dietary requirements, restrictions, fluid needs, tube feedings, and total parenteral nutrition.

Element 13 — Mental Status
Enter an "X" next to the term(s) that most accurately describes the recipient's mental status. If "Other" is checked, provide further explanation.

Element 14 — Prognosis
Enter an "X" next to the one term that specifies the most appropriate prognosis of the recipient.

SECTION IV — ORDERS

Element 15 — Orders for Services and Treatments
Indicate the following as appropriate for each individual service:

- Number of recipient visits (e.g., home health skilled nursing, home health aide, or medication management), frequency of visits, and duration of visits ordered by the attending physician's orders (e.g., 1 visit, 3 times/week, for 9 weeks).
- Number of hours required for recipient visits (e.g., private duty nursing [PDN] or personal care), frequency of visits, and duration of visits ordered by the attending physician's orders (e.g., 8 hours/day, 7 days/week, for 9 weeks).
- Duties and treatments to be performed.
- Methods for delivering care and treatments.
- Procedures to follow in the event of accidental extubation, as applicable.
- Ventilator settings and parameters, as applicable.

Services include, but are not limited to, the following:

- Home health skilled nursing.
- Home health aide.
- Private duty nursing.

Orders must include all disciplines providing services for the recipient and all treatments the recipient receives regardless of whether or not the services are billable to Wisconsin Medicaid. Orders indicated on this POC should be as detailed and specific as those ordered and written by the attending physician.

Pro re nata (PRN), or "as needed," home care visits or hours may be ordered on a recipient's POC only when indicating how these visits or hours will be used in a manner that is specific to the recipient's potential needs. Both the nature of the services provided and the number of PRN visits or hours to be permitted for each type of service *must* be specified. Open-ended, unqualified PRN visits or hours do not constitute an attending physician's orders because both the nature and frequency of the visits or hours *must* be specified.

Nurses in independent practice (NIP) are required to include the name and license number of the registered nurse (RN) providing coordination services under this element. An NIP that is a licensed practical nurse is required to include the name and license number of the RN supervisor under this element.

Element 16 — Goals / Rehabilitation Potential / Discharge Plans
Enter the attending physician's description of the following:

- Achievable and measurable goals for the recipient.
- The recipient's ability to attain the set goals, including an estimate of the length of time required to attain the goals.
- Plans for the recipient's care after discharge.

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

Element 17 — Date Physician Last Saw Recipient
Enter the date the attending physician last saw the recipient in MM/DD/YY format. If this date cannot be determined during the home visit, enter "Unknown."

Element 18 — Dates of Last Inpatient Stay Within 12 Months
Enter the admission and discharge dates of the recipient's last inpatient stay within the previous 12 months, if known. Enter "N/A" if this element does not apply to the recipient.

Element 19 — Type of Facility for Last Inpatient Stay
Enter one of the following single-letter responses to identify the type of facility of the recipient's last inpatient stay, if applicable:

- A (Acute hospital).
- S (Skilled nursing facility).
- R (Rehabilitation hospital).
- I (Intermediate care facility).
- O (Other).
- U (Unknown).

This element must be completed if a surgical procedure was entered in Element 6. Enter "N/A" if this element does not apply to the recipient.

Element 20 — Current Information
For initial certifications, enter the clinical findings of the initial assessment visit for each discipline involved in the POC. Describe the clinical facts about the recipient that require home care services and include specific dates in MM/DD/YY format.

For recertifications, enter significant clinical findings about the recipient's symptoms, new orders, new treatments, and any changes in the recipient's condition during the past 60 days for each discipline involved in the POC. Document both progress and nonprogress for each discipline. Include specific dates in MM/DD/YY format.

Include any pertinent information about any of the recipient's inpatient stays and the purpose of contact with the physician, if applicable.

Element 21 — Home or Social Environment
Enter information that will justify the need for home care services and enhance the Wisconsin Medicaid consultant's understanding of the recipient's home situation (e.g., recipient lives with mentally disabled son who is unable to provide care or assistance to recipient). Include the availability of caretakers (e.g., parent's work schedule). The description may document problems that are, or will be, an impediment to the effectiveness of the recipient's treatment or rate of recovery.

Element 22 — Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home
Enter all reasons that the recipient leaves home. Indicate both medical and nonmedical reasons, including frequency of occurrence of the trips (e.g., doctor appointment twice a month, barbershop once a month, school every weekday for three hours).

Element 23 — Back-up for Staffing and Medical Emergency Procedures
This element is required for all providers requesting PDN services. It is optional for all other home care providers.

Enter the back-up plan for staffing and medical emergency procedures. The following information must be included in this element:

- A plan for medical emergency, including:
  - ✓ A description of back-up personnel needed.
  - ✓ Provision for reliable, 24 hours a day, 7 days a week emergency service for repair and delivery of equipment.
  - ✓ Specification of an emergency power source.
- A plan to move the recipient to safety in the event of fire, flood, tornado warning or other severe weather, or any other condition which threatens the recipient's immediate environment.

SECTION VI — SIGNATURES

Those signing the POC are to acknowledge their responsibilities and consequences for non-compliance. Provider-created formats must contain the following statement that is included on the PA/HCA:

> *"Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal law."*

Element 24 — Signature — Authorized Nurse Completing Form
The nurse completing this PA/HCA is required to sign this form. The signature certifies that the nurse has received authorization from the attending physician to begin providing services to the recipient.

Provider-created formats must contain the following statement accompanying the authorized nurse's signature:

> *"As the nurse completing this plan of care, I confirm the following: All information entered on this form is complete and accurate. I am familiar with all information entered on this form. I am responsible for ensuring that the plan of care is carried out as specified. I have received authorization from the attending physician to provide services to the recipient. I have reviewed the information in this document with the attending physician on the date specified."*

(The date specified refers to the date requested in Element 25.)

Element 25 — Date Reviewed with Attending Physician
Enter the date the nurse signing in Element 24 reviewed the information contained in this document with the attending physician.

Element 26 — Date Received Physician-Signed Form
Enter the date the PA/HCA signed by the attending physician was received by the nurse or in the agency.

Element 27 — Name and Address — Attending Physician
Enter the attending physician's name and complete address. The street, city, state, and zip code must be included. The attending physician establishes the POC, certifies, and recertifies the medical necessity of the visits and/or services provided.

Elements 28 and 29 — Signature and Date Signed — Attending Physician
The attending physician is required to sign and date the PA/HCA within 20 working days following the initial start of care. A recertification of the POC requires the attending physician to sign and date the new PA/HCA prior to the continued provision of services to the recipient.

Provider-created formats must contain the following statement accompanying the attending physician's signature:

"The recipient is under my care, and I have authorized the services on this plan of care."

Verbal authorization may be obtained from the attending physician for the initial certification period PA request. The recipient may then begin receiving home care services; however, the attending physician is required to sign the PA/HCA within 20 working days of the start of care date.

The attending physician may not give verbal authorization for certification period renewal PA requests. The attending physician is required to sign the PA/HCA prior to the continued provision of services to the recipient; home care services may not be provided until the attending physician's signature is obtained on the form.

The form may be signed by another physician who is authorized by the attending physician to care for the recipient in his or her absence.

The nurse or agency staff may not predate the PA/HCA for the attending physician or write the date in the field after it has been returned. If the attending physician has left Element 29 blank, the nurse or agency staff should enter the date the signed PA/HCA was received in Element 26.

ATTACHMENT 3
Prior Authorization/Home Care Attachment (PA/HCA)

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

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11096 (09/05)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for detailed information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Prior Authorization Number	2. Name and Telephone Number — Recipient
3. Start of Care Date	4. Certification Period From To

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment

8a. Functional Limitations

- 1 ❑ Amputation
- 2 ❑ Bowel / Bladder (Incontinence)
- 3 ❑ Contracture
- 4 ❑ Hearing
- 5 ❑ Paralysis
- 6 ❑ Endurance
- 7 ❑ Ambulation
- 8 ❑ Speech
- 9 ❑ Legally Blind
- 10 ❑ Dyspnea with Minimal Exertion
- 11 ❑ Other (Specify in Element 8b)

8b. If “Other” checked in Element 8a, specify other functional limitations.

9a. Activities Permitted

- 1 ❑ Complete Bedrest
- 2 ❑ Bedrest BRP
- 3 ❑ Up As Tolerated
- 4 ❑ Transfer Bed / Chair
- 5 ❑ Exercises Prescribed
- 6 ❑ Partial Weight Bearing
- 7 ❑ Independent at Home
- 8 ❑ Crutches
- 9 ❑ Cane
- 10 ❑ Wheelchair
- 11 ❑ Walker
- 12 ❑ No Restrictions
- 13 ❑ Other (Specify in Element 9b)

9b. If “Other” checked in Element 9a, specify other activities permitted.

10. Medications (Dose / Frequency / Route)

11. Allergies

12. Nutritional Requirements

13. Mental Status 1 ❑ Oriented 3 ❑ Forgetful 5 ❑ Disoriented 7 ❑ Agitated 2 ❑ Comatose 4 ❑ Depressed 6 ❑ Lethargic 8 ❑ Other ________

14. Prognosis 1 ❑ Poor 2 ❑ Guarded 3 ❑ Fair 4 ❑ Good 5 ❑ Excellent

Continued

Prior Authorization Number

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

16. Goals / Rehabilitation Potential / Discharge Plans

Continued

Prior Authorization Number

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Recipient	18. Dates of Last Inpatient Stay Within 12 Months (If Known) Admission Discharge	19. Type of Facility for Last Inpatient Stay (If Applicable)

20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

21. Home or Social Environment

22. Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home (Include Frequency)

23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

SECTION VI — SIGNATURES

Nurse Certification

As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate. I am familiar with all information entered on this form. I am responsible for ensuring that the plan of care is carried out as specified. I have received authorization from the attending physician to provide services to the recipient. I have reviewed the information in this document with the attending physician on the date specified. (The date specified refers to the date entered in Element 25 of this form.)

24. **SIGNATURE** — Authorized Nurse Completing Form	25. Date Reviewed with Attending Physician	26. Date Received Physician-Signed Form

Physician Certification

The recipient is under my care, and I have authorized the services on this PA/HCA.

27. Name and Address — Attending Physician (Street, City, State, Zip Code)

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

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

ATTACHMENT 4
Private Duty Nursing Prior Authorization Acknowledgment

(A copy of the "Private Duty Nursing Prior Authorization Acknowledgment" is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11041 (Rev. 09/05)

WISCONSIN MEDICAID
PRIVATE DUTY NURSING PRIOR AUTHORIZATION ACKNOWLEDGMENT

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 information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form.

INSTRUCTIONS

1. Allow the recipient, or recipient's parent, guardian, or legal representative, to read the plan of care and prior authorization (PA) request. Answer any questions the recipient may have.

2. Have the recipient or the recipient's legal representative sign and date this form.

3. Attach this completed form to the Prior Authorization Request Form (PA/RF), HCF 11018, and/or Prior Authorization Amendment Request, HCF 11042.

4. For more information on private duty nursing documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Name — Recipient	Recipient Medicaid Identification Number
Prior Authorization Number	

I have read the attached Plan of Care and the PA request.

Name — Person Signing Form (Print)	Relationship to Recipient (If Person Signing Form Is Not Recipient)
SIGNATURE — Person Signing Form Check one of the following to identify person signing form. ❏ Recipient ❏ Recipient's Parent ❏ Guardian ❏ Legal Representative	Date Signed