ForwardHealth
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Update
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**Affected Programs:** BadgerCare Plus, Medicaid
**To:** All Providers, HMOs and Other Managed Care Programs

# Separate Prior Authorization Is Required for the BadgerCare Plus Benchmark Plan

Providers must obtain prior authorization (PA) separately for the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan for the same or similar services. When a member switches between the two plans, PA granted under one plan will not be valid for the other plan. This *ForwardHealth Update* describes the PA procedures that providers must follow when a member's enrollment status changes.

Effective immediately, providers must obtain prior authorization (PA) separately for the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan for the same or similar services. If a member's enrollment status changes, PA granted under one plan will not be valid for the other plan. Providers are required to submit new PA requests in these cases to obtain a valid PA for the member. Separate PAs are required because of differences in coverage between the Benchmark Plan and Standard Plan.

Members who switch between the Standard Plan and Medicaid do not need a separate PA on file; however, members who switch between the Benchmark Plan and Medicaid do need a separate PA on file.

## Prior Authorization and Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA determinations. In the following cases, providers are required to obtain valid, approved PA for those services that require PA:

- A member enrolled in the Standard Plan has a change in income level and becomes eligible for the Benchmark Plan. The member's enrollment status changes to Benchmark Plan.
- A member enrolled in the Benchmark Plan has a change in income level or medical condition and becomes eligible for the Standard Plan or Medicaid. The member's enrollment status changes to Standard Plan or Medicaid accordingly.

Some changes in member enrollment status do not affect PA determinations. In the following cases, providers are not required to obtain separate PA because PA will continue to be valid:

- A member enrolled in the Standard Plan becomes eligible for Medicaid coverage. Prior authorization granted under the Standard Plan will be valid for Medicaid.
- A member switches from the Standard Plan to the Benchmark Plan and there is already a valid PA on file for the member under the Benchmark Plan.
- A member switches from the Benchmark Plan to the Standard Plan or Medicaid and there is already a valid PA on file for the member under the Standard Plan or Medicaid.

Providers are encouraged to verify enrollment before **every** office visit or service rendered. Verifying

enrollment will help providers identify changes in member enrollment status and take appropriate actions to obtain PA for services when necessary.

## Prior Authorization Procedures

The procedures for submitting a PA request are the same for the Standard Plan and the Benchmark Plan. The first time a member switches plans, the provider is required to submit a new PA request, including all required PA forms and attachments. If a member switches back into either of the plans and there is a valid, approved PA on file under that plan, the provider does not need to submit a new PA request.

Providers who have a provider account on the ForwardHealth Portal may use the Portal to check if a valid PA is on file for the service.

### *Prior Authorization Requirements*

Providers should be aware that PA requirements may be different for the Benchmark Plan. Some services that require PA under the Standard Plan or Medicaid may not require PA under the Benchmark Plan. If a member switches into the Standard Plan or Medicaid, providers should check if services require PA under those plans even if the member did not need PA while enrolled in the Benchmark Plan.

### *Calculating Limits for Services Requiring Prior Authorization*

Any limits that pertain to services requiring PA will accumulate separately under each plan.

For instance, 30 home health visits are allowed per calendar year under the Standard Plan before PA is required. Under the Benchmark Plan, 30 home health visits are allowed per enrollment year before PA is required. A member is enrolled in the Standard Plan and obtains PA for five additional visits, bringing his total to 35 home health visits. The member's enrollment status changes after the 35th visit and he is then enrolled in the Benchmark Plan. Under the Benchmark Plan, the member may receive up to 30 home health visits before he requires PA. After his 30th visit, the provider is required to submit PA materials and obtain PA for any visits that exceed 30.

### *Prior Authorization for Members Requiring Ongoing Services*

For members who require ongoing services that need PA, such as daily oxygen, providers should always check member enrollment status before providing services. If a valid, approved PA is not on file for the member under the plan in which he or she is enrolled, the provider should request PA. Providers may backdate new PA requests in accordance with current backdating policies and procedures to accommodate changes in member enrollment status.

## Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. BadgerCare Plus HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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