wisconsin Medicaid update
department of health and family services
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POH 1635

To:
Audiologists
Hearing Instrument Specialists (formerly hearing aid suppliers)
HMOs and Other Managed Care Programs
Speech and Hearing Clinics
Physicians
Hospitals
Nursing Homes
Ambulatory Surgical Centers

New PA Forms for Audiologists and Hearing Instrument Specialists

This Update introduces the revised Wisconsin Medicaid prior authorization (PA) forms for hearing devices (prosthetic devices for hearing loss) provided by audiologists and hearing instrument specialists (formerly hearing aid suppliers).

This Update applies to fee-for-service Medicaid providers only. If you are a Medicaid managed care provider, contact your managed care organization (MCO) for information about their procedures.

New PA Forms

Effective March 1, 1999, Wisconsin Medicaid will be using the following revised PA forms:

- Prior Authorization Request Form Physician Otological Report (PA/POR), which replaces the Physician Otological Report for Hearing Aid Evaluation Form (PA/OF). (Completed by physicians and submitted by hearing instrument specialists.)
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1), which replaces the Audiological Prior Authorization Request Form (PA/ARF1). (Used by both audiologists and hearing instrument specialists.)
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2), which replaces the Audiological Prior Authorization Request Form (PA/ARF2). (Used by both audiologists and hearing instrument specialists.)

Samples of the new forms are attached to this Update.

You will be able to use the existing forms until July 31, 1999. The new forms are required for new PAs requested on or after August 1, 1999.

Ordering Revised PA Forms

The PA/POR, PA/HIAS1, and PA/HIAS2 forms are available from the Wisconsin Medicaid fiscal agent, EDS. You will receive three copies of each of the new forms along with an order form to request more copies in another mailing. Send form requests to:

Form Reorder
EDS
6406 Bridge Road
Madison, WI 53784-0003

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For provider questions, call the Medicaid fiscal agent, EDS, at (800) 947-9627 or (608) 221-9883.

DO NOT DETACH

WISCONSIN MEDICAID FORM PA/POR

PRIOR AUTHORIZATION REQUEST FORM

PHYSICIAN OTOLOGICAL REPORT

This form is required by Wisconsin Medicaid when a hearing instrument specialist requires prior authorization for a hearing instrument.

- COMPLETE EACH ITEM ON FORM.
- GIVE FIRST PAGE TO THE RECIPIENT TO TAKE TO THE TESTING CENTER.
- RETAIN SECOND PAGE FOR YOUR FILES.

1 PHYSICIAN NAME, ADDRESS (STREET, CITY, STATE, ZIP CODE)	2 EVALUATION DATE MM/DD/YYYY	3 PHYSICIAN'S SIGNATURE AND DATE M.D. SIGNATURE MM/DD/YYYY
	4 PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER	5 PHYSICIAN'S TELEPHONE NUMBER ( )

6 RECIPIENT'S MEDICAID ID NUMBER — — — — — — — — — —	7 SEX M ☐ F ☐	8 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
9 RECIPIENT'S NAME (LAST, FIRST, M.I.) AS ON MEDICAID ID CARD	10 DATE OF BIRTH	

11 MEDICAL HISTORY OF HEARING LOSS

12 PERTINENT OTOLOGICAL FINDINGS

		NORMAL (Check below)	PROBLEMS (Describe)
RIGHT	Canal	[ ]	______________
	Ear Drum	[ ]	______________
	Middle Ear	[ ]	______________
LEFT	Canal	[ ]	______________
	Ear Drum	[ ]	______________
	Middle Ear	[ ]	______________

13 ADDITIONAL FINDINGS
e.g. results of special studies, such as caloric and postural tests (describe):

14 CLINICAL DIAGNOSIS OF HEARING STATUS

15 MEDICAL, COGNITIVE, OR DEVELOPMENTAL PROBLEMS

16 PHYSICIAN'S RECOMMENDATIONS (Check all applicable)

[ ] I have medically evaluated this patient and refer him/her for a hearing instrument evaluation as follows:

[ ] One or more of the situations listed below applies to this patient. Therefore, as required by Medicaid regulations, I refer this patient to an audiologist for a hearing instrument evaluation/diagnosis:

[ ] The patient is 21 years of age or under.

[ ] The patient is behaviorally or cognitively impaired.

[ ] The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.

[ ] None of the above situations applies to this patient. Either an audiologist or a hearing instrument specialist may provide the hearing instrument evaluation.

[ ] A home hearing test may be required.

COMPLETION INSTRUCTIONS FOR PA/POR

This form is required by Wisconsin Medicaid when a hearing instrument specialist requires prior authorization for a hearing instrument.

ELEMENT 1 - PHYSICIAN NAME, ADDRESS
Enter the name and address, including zip code, of the requesting physician.

ELEMENT 2 - EVALUATION DATE
Enter the date the recipient was examined in MM/DD/YYYY format.

ELEMENT 3 - PHYSICIAN'S SIGNATURE AND DATE
The requesting physician must sign the form and enter the date the request is made.

ELEMENT 4 - PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER
Enter the eight-digit Medicaid provider number, six-digit Medicare Universal Provider Identification Number (UPIN), or license number of the physician.

ELEMENT 5 - PHYSICIAN'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the requesting physician.

ELEMENT 6 - RECIPIENT'S MEDICAID ID NUMBER
Enter the recipient's complete 10-digit Medicaid identification number as it appears on his/her Medicaid identification card.

ELEMENT 7 - SEX
Enter an 'X' in the appropriate box.

ELEMENT 8 - RECIPIENT ADDRESS
Enter the complete address, including zip code, of the recipient's place of residence. If the recipient is a nursing home resident, indicate the name of the nursing home.

ELEMENT 9 - RECIPIENT'S NAME
Enter the recipient's last name, first name, and middle initial as they appear on his/her Medicaid identification card.

ELEMENT 10 - DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YYYY format.

ELEMENT 11 - MEDICAL HISTORY OF HEARING LOSS
Enter the recipient's medical history of hearing loss (if any).

ELEMENT 12 - PERTINENT OTOLOGICAL FINDINGS
Enter an 'X' in the appropriate box(es) and describe all problems.

ELEMENT 13 - ADDITIONAL FINDINGS
Describe any additional findings not covered in element 11.

ELEMENT 14 - CLINICAL DIAGNOSIS OF HEARING STATUS
Enter the diagnosis of the recipient's hearing status.

ELEMENT 15 - MEDICAL, COGNITIVE, OR DEVELOPMENTAL PROBLEMS
Describe any medical cognitive or developmental problems of the recipient.

ELEMENT 16 - PHYSICIAN'S RECOMMENDATIONS
Enter an 'X' in the appropriate box(es) to indicate the physician's recommendations.

DO NOT DETACH

WISCONSIN MEDICAID FORM PA/HIAS1

PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES

MAIL TO:
PRIOR AUTHORIZATION UNIT
EDS
SUITE 88
6406 BRIDGE ROAD
MADISON, WI 53784-0088

(DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. #

PROCESSING TYPE **123**

1 TESTING CENTER NAME AND ADDRESS

2 TESTING CENTER PROVIDER NO.

3 TESTING CENTER TELEPHONE NO.
( )

4 REQUESTING HIS OR AUDIOLOGIST NAME

5 REQUESTING HIS OR AUDIOLOGIST PROVIDER NUMBER

6 RECIPIENT'S MEDICAID ID NUMBER

7 RECIPIENT'S DATE OF BIRTH

8 RECIPIENT'S NAME (LAST, FIRST, M.I.) AS ON MEDICAID CARD.

9 REFERRING PHYSICIAN'S NAME

10 REFERRING PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER

11 RECIPIENT'S ADDRESS

12 DIAGNOSIS

REQUESTED SERVICES

13 POS	14 TOS	15 PROCEDURE CODE	16 DESCRIPTION (NOT BRAND NAME)	17 QUANTITY	18 CHARGE
				TOTAL CHARGES	19

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

21 PROVIDER TYPE (CHECK ONE):
- 9 AUDIOLOGIST
- 9 HEARING INSTRUMENT SPECIALIST

20 ______________________ SIGNATURE

22 ______________ MM/DD/YYYY

FOR COMPLETION BY MEDICAID AUDIOLOGY CONSULTANT

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

☐ APPROVED

GRANT DATE

EXPIRATION DATE

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

SIGNATURE OF MEDICAID AUDIOLOGY CONSULTANT

DATE

COMPLETION INSTRUCTIONS FOR PA/HIAS1

ELEMENT 1 - TESTING CENTER NAME AND ADDRESS
Enter the name and address, including zip code, of the testing center.

ELEMENT 2 - TESTING CENTER PROVIDER NUMBER
Enter the eight-digit Medicaid provider number of the testing center.

ELEMENT 3 - TESTING CENTER TELEPHONE NUMBER
Enter the telephone number, including area code, of the testing center.

ELEMENT 4 - REQUESTING HIS OR AUDIOLOGIST NAME
Enter the name of the requesting hearing instrument specialist (HIS) or audiologist.

ELEMENT 5 - REQUESTING HIS OR AUDIOLOGIST PROVIDER NUMBER
Enter the eight-digit Medicaid provider number of the requesting hearing instrument specialist (HIS) or audiologist.

ELEMENT 6 - RECIPIENT'S MEDICAID ID NUMBER
Enter the recipient's complete 10-digit Medicaid identification number as it appears on his/her Medicaid identification card.

ELEMENT 7 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YYYY format.

ELEMENT 8 - RECIPIENT'S NAME
Enter the recipient's last name, first name, and middle initial as they appear on his/her Medicaid identification card.

ELEMENT 9 - REFERRING PHYSICIAN'S NAME
Enter the name of the referring physician.

ELEMENT 10 - REFERRING PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER
Enter the eight-digit Medicaid provider number, six-digit Medicare Universal Provider Identification Number (UPIN), or license number of the physician.

ELEMENT 11 - RECIPIENT'S ADDRESS
Enter the complete address, including zip code, of the recipient. If the recipient is a nursing home resident, indicate the name of the nursing home.

ELEMENT 12 - DIAGNOSIS
Enter an *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code and written description of the recipient's diagnosis.

ELEMENT 13 - PLACE OF SERVICE (POS)
Enter the appropriate place of service as listed on the table below:

Inpatient hospital	1
Outpatient hospital	2
Office	3
Home	4
NH/Extended Care Facility	7
Skilled Nursing Facility	8
Other	0
Ambulatory Surgical Center	B

ELEMENT 14 - TYPE OF SERVICE (TOS)
Enter type of service ‘P’ for purchase of hearing instrument or ‘R’ for rental of hearing instrument.

ELEMENT 15 - PROCEDURE CODE
Enter the appropriate procedure code for the hearing instrument requested.

ELEMENT 16 - DESCRIPTION
Enter a narrative description of the type or like model of hearing instrument requested. Do not indicate brand or make.

ELEMENT 17 - QUANTITY
Enter the quantity to be dispensed.

ELEMENT 18 - CHARGE
When the service is a complete hearing instrument package, enter the actual or best estimate of the net cash outlay cost. For all other services, enter the usual and customary charge.

ELEMENT 19 - TOTAL CHARGES
Enter the total of all charges in element 19.

ELEMENT 20 - SIGNATURE
The signature of the requesting audiologist or hearing instrument specialist is required in this element.

ELEMENT 21 - PROVIDER TYPE
Indicate if the provider is an audiologist or a hearing instrument specialist.

ELEMENT 22 - DATE
Enter the date the requesting audiologist or hearing instrument specialist signed the request.

NOTE: If all elements are not completed, the request will be returned.

DO NOT DETACH

WISCONSIN MEDICAID FORM PA/HIAS2

PRIOR AUTHORIZATION REQUEST FOR
HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES

MAIL TO:
PRIOR AUTHORIZATION UNIT
EDS
SUITE 88
6406 BRIDGE ROAD
MADISON, WI 53784-0088

1 PROVIDER NUMBER

2 PROVIDER NAME, ADDRESS, ZIP CODE

3 TELEPHONE NUMBER
( )

4 RECIPIENT'S MEDICAID ID NUMBER

5 RECIPIENT'S NAME (LAST, FIRST, M.I.) AS ON MEDICAID ID CARD

6 TESTING DATE
MM/DD/YYYY

7 TEST RELIABILITY (CIRCLE ONE)
GOOD FAIR POOR

8 SEX
M ☐ F ☐

9 RECIPIENT'S DATE OF BIRTH
MM/DD/YYYY

10 HAS THE RECIPIENT EVER USED A HEARING INSTRUMENT?
☐ YES ☐ NO

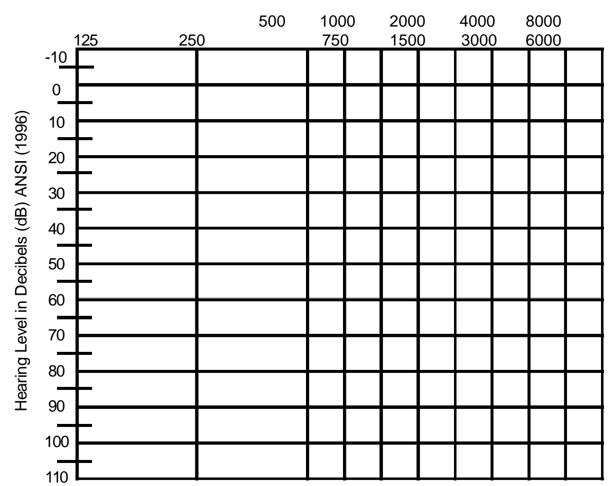
11 DESCRIBE PRIOR HEARING INSTRUMENT USE

Legend

Ear	Color	Air Un masked	Air Masked	Bone Un masked	Bone Masked	NA
Right	Red	o-o	△-△	<	[	↙
Left	Blue	x-x	☐ ☐	>	]	↘

SPEECH AUDIOMETRY	R	L	SF	Aided: Own Aid ☐ Test Aid ☐
Threshold (SRT)				
Word recognition in quiet				
Word recognition in noise				
Uncomfortable level (dB-HL)				
Most comfortable level (dB-HL)				

13 PURE TONE AUDIOGRAM
Frequency in Hertz (Hz)



14 DESCRIBE ANY ADDITIONAL AUDIOLOGIC STUDIES PERFORMED AND PERTINENT RESULTS (USE AN ATTACHMENT IF NECESSARY)

15 RECOMMENDATIONS FOR A HEARING INSTRUMENT

EAR MOLD STYLE:

EAR: (CHECK ONE) **LEFT** **RIGHT** ☐ **BOTH** ☐ ☐ **EAR MOLD** **LEFT** **RIGHT** ☐ **BOTH** ☐ ☐

STYLE:

SPECIAL MODIFICATIONS:

DESCRIBE ELECTROACOUSTIC SPECIFICATIONS:

DESCRIBE OR ATTACH PERTINENT SOCIAL BACKGROUND AND OTHER RELEVANT INFORMATION:

17 PROVIDER TYPE (CHECK ONE):
9 AUDIOLOGIST
9 HEARING INSTRUMENT SPECIALIST

16 ______________________________
SIGNATURE

18 ______________________________
DATE (MM/DD/YYYY)

COMPLETION INSTRUCTIONS FOR PA/HIAS2

ELEMENT 1 - PROVIDER NUMBER
Enter the eight-digit Medicaid provider number of the requesting audiologist or hearing instrument specialist if applicable.

ELEMENT 2 - PROVIDER NAME, ADDRESS, ZIP CODE
Enter the name and address, including zip code, of the requesting audiologist or hearing instrument specialist.

ELEMENT 3 - TELEPHONE NUMBER
Enter the telephone number, including area code, of the requesting audiologist or hearing instrument specialist.

ELEMENT 4 - RECIPIENT'S MEDICAID ID NUMBER
Enter the recipient's 10-digit Medicaid identification number as it appears on his/her Medicaid identification card.

ELEMENT 5 - RECIPIENT'S NAME
Enter the recipient's last name, first name, and middle initial as they appear on his/her Medicaid identification card.

ELEMENT 6 - TESTING DATE
Enter the date, in MM/DD/YYYY format, of the audiological testing/evaluation.

ELEMENT 7 - TEST RELIABILITY
Circle the proper reliability of the test.

ELEMENT 8 - SEX
Enter an 'X' in the appropriate box.

ELEMENT 9 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YYYY format.

ELEMENT 10 - HAS THE RECIPIENT EVER USED A HEARING INSTRUMENT?
Enter an 'X' in the appropriate box.

ELEMENT 11 - DESCRIBE PRIOR HEARING INSTRUMENT USE
Describe the patient's prior hearing instrument use.

ELEMENTS 12 - 14
Document all audiological testing and results.

ELEMENT 15 - RECOMMENDATIONS FOR A HEARING INSTRUMENT
Describe recommendations for a hearing instrument.

ELEMENT 16 - SIGNATURE
The signature of the requesting audiologist or hearing instrument specialist is required in this element.

ELEMENT 17 - PROVIDER TYPE
Indicate if the provider is an audiologist or a hearing instrument specialist.

ELEMENT 18 - DATE
Enter the date the requesting audiologist or hearing instrument specialist signed the request.

Dept. of Health & Family Services
Division of Health Care Financing
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P.O. Box 309
Madison, WI 53701-0309

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