wisconsin Medicaid update
department of health and family services
August 1999 • No. 99-31
POH 1671

To:
DME Vendors
HMOs
Home Health Agencies
Hospitals-outpatient
Nursing Homes
Occupational Therapists
Orthotists and Prosthetists
Pharmacists
Physical Therapists
Rehabilitation Agencies
Therapy Groups

Tips for providing orthotics to Medicaid recipients

The purpose of this Update is to clarify therapists' questions regarding how and when to obtain prior authorization and submit claims for orthotics. The tips included in this Update will help therapists who provide orthotics to Medicaid recipients.

This Update applies to fee-for-service Medicaid providers only. If you are an HMO network provider, contact your managed care organization for more information about their procedures. Medicaid covers the same orthotics for recipients in both fee-for-service and managed care programs.

Orthotics reimbursed as durable medical equipment

Orthotics are reimbursed as durable medical equipment (DME) and *not* as therapy. When submitting prior authorization (PA) requests or claims for all orthotics, use the appropriate HCFA Common Procedure Coding System (HCPCS) or local Wisconsin Medicaid codes contained in the Wisconsin DME Index. Wisconsin Medicaid does not accept any *Current Procedural Terminology* (CPT) codes for orthotics from therapists.

Current codes/maximum allowable fees

Check the current Wisconsin Medicaid DME Index/maximum allowable fees (MAF) for the code that best describes the orthotics being provided.

The DME Index/MAF indicates the procedure codes and descriptions, maximum allowable fee for each procedure, modifiers, allowable provider types, PA requirement indicator, types of service, and other reimbursement information. Refer to Attachment 1 of this Update for instructions on how to read the DME Index/MAF.

The DME Index/MAF can be obtained from Wisconsin Medicaid. Refer to Appendix 38 of Part A, the all-provider handbook, for a fee schedule order form, which includes the comprehensive DME Index/MAF or the DME indices specific to certain providers. The DME indices are also available on the Wisconsin Medicaid web site at: *www.dhfs.state.wi.us/Medicaid/maxfees/maxfee.htm.* You may purchase copies of the DME Index/MAF by writing to the address below:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Bilateral orthotics

The DME Index/MAF identifies which items are dispensed as a pair and billed with a quantity of one and items referred to as

"bilateral appliances." Bilateral appliances may be sold singly (each) or as a pair, with a quantity of one or more.

If bilateral appliances are billed for the same date of service on the same claim form, indicate a single detail with a quantity of "2" or more in element 24G of the HCFA 1500 claim form.

If bilateral appliances are billed for different dates of service, indicate modifier "01" with the procedure code of the additional appliance billed with a quantity of "1". If the modifier is not indicated on the subsequent claim, the additional service is denied.

For example, if a left "WHFO; wrist extension cock-up; dorsal wrist," procedure code L3938, is billed with a May 1, 1999, date of service with a quantity of one, and a right "WHFO; wrist extension cock-up; dorsal wrist," procedure code L3938, is billed for the same recipient with a June 1, 1999, date of service, the claim for the additional appliance must have the modifier "01" and a quantity of one. The modifier differentiates the additional service from the first. Without the modifier, the additional service will be denied.

When HCPCS codes are not applicable

When a unique and custom-made orthotic is fabricated, and no HCPCS code describes the unique custom-made orthotic, use not otherwise classified (NOC) procedure code L2999 (lower extremity orthoses, not otherwise specified) or L3999 (upper limb orthosis, not otherwise specified).

These codes can be bilateral and require PA *only* if the cost of *each* orthotic is $150 or more.

An approved PA contains consultant-approved pricing and may have assigned modifiers (11-35) if one or more items is approved under the same NOC code. Modifiers assigned during PA must be used when billing for these specific authorized items or the claim will be denied. Refer to the appropriate therapy handbook for instructions on obtaining PA.

A paper claim form is required when billing for these unspecified codes.

Prior authorization requirements

Prior authorization is required if a custom orthotic is $150 or more for the complete service. Submit a Prior Authorization Request Form (PA/RF) and a Prior Authorization Durable Medical Equipment Attachment (PA/DMEA). All PA requests must include:

- A copy of the physical therapist's (PT) or occupational therapist's (OT) entire evaluation.
- A physician's signed and dated prescription, which must be dated within six months of the date of service.
- The functional purpose of the orthotic (e.g., the recipient will receive maximum stability in a specified area to perform a needed function or will prevent an increase in severity of deformity).

For an example of a PA request for a single custom orthotic with a charge of $150 or more, see Attachments 2a and 2b.

What's included in the reimbursement

Wisconsin Medicaid's reimbursement of all orthotics includes evaluation time, fitting time, fabrication time, materials, and follow-up time. Because these tasks are included in the reimbursement, ***they may not be billed separately as therapy.***

Wisconsin Medicaid's reimbursement of all orthotics includes evaluation time, fitting time, fabrication time, materials, and follow-up time.

Definitions of these tasks are:

- Evaluation time - identifies minutes spent and charge.
- Fitting time - identifies minutes spent and charge.
- Fabrication time - identifies minutes spent and charge.
- Materials - identifies type of materials and charge.
- Follow-up session time - identifies time spent and charge (covers a few 5-minute sessions).

Note: Adjusting an orthotic device (e.g., changing the angle of the orthotic or flaring it out) is not a separately reimbursable charge, per HFS 107.24(5), Wis. Admin. Code.

For auditing purposes, providers are required to retain in their files all time, materials, and charge information. However, when PA is required, providers must indicate this information in Section H of the PA/DMEA. For examples of how this information should be filed, see Section H of Attachments 2b and 4b.

Soft orthotics for nursing home recipients

Soft orthotics are not custom-made to one person and should be considered the same as hand cones or similar pre-formed positioning items. These items are not separately billable for nursing home recipients. They are reimbursed through the nursing home daily rate and include items such as:

- Soft elbow or knee orthotics.
- Soft gel palm shields.
- Palm and foot protectors.
- Inflatable hand orthotics.
- Foam arm elevators.
- Elbow, hip, and knee wedges.
- Hand cones.
- Air orthotics.

Because the above items are reimbursed in the nursing home daily rate and the therapist cannot bill separately for the item, an evaluation (procedure code 97003 for OT and 97001 for PT) and one to two sessions for follow-up may be billed as therapy (procedure code 97110). If any nursing home resident, like all Medicaid recipients, has exceeded the initial 35-visit limit, PA is required for the therapy evaluation and follow-up. Attachments 3a, a PA/RF, and 3b, a Prior Authorization Therapy Attachment (PA/TA) are examples of the PA request for therapy with an item included in the daily rate of a nursing home. Note on Attachment 3a that the evaluation and follow-up procedures have been identified separately. The therapist should clearly identify in Section H of the PA/TA that the item is reimbursed in the facility's daily rate.

Instruction to nursing home staff in the above positioning or soft orthotics techniques without recipient involvement is not separately reimbursable.

Serial splinting or casting

Use PA/RF and PA/DMEA forms to obtain PA for serial splinting or casting. For an example of a PA request for serial splinting, see Attachments 4a and 4b. Note that each splint needs to be identified individually on the PA/RF.

Repair of orthotic device L4210

When repairs are required for orthotics the following policies apply:

- Any entire repair service in excess of $150 per date of service always requires PA.
- Repairs under $150 per complete repair do *not* require PA.
- Bill orthotic repair as DME on a HCFA 1500 claim form. Use claim sort indicator "D," as in DME, in element 1, and the procedure code "L4210."
- When using unlisted or unspecified codes,

(L4210, L2999, and L3999) always use a paper claim form because the narrative is used for manual pricing.

- If the specific repair necessary is under $150, you may describe the procedure in element 19 of the paper HCFA 1500 claim form or separately attach this information to the claim form if there is not enough space for the description.

See Attachment 5 for a guide to PA and billing for orthotics.

For more information about obtaining PA for orthotics, contact Provider Services at (800) 947-9627 or (608) 221-9883.

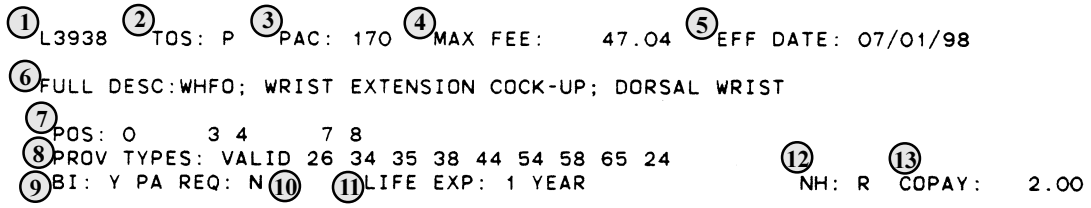
The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

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

For provider questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our web site at *www.dhfs.state.wi.us/medicaid.*

Attachment 1

How to Read the Durable Medical Equipment Index/Maximum Allowable Fee Report: An Example



1. "L3938" is the five-character HCFA Common Procedure Coding System (HCPCS) procedure code.

2. "TOS" is the one-character type of service (TOS) code indicating whether the item may be rented (R) or, as in this case, must be purchased (P).

3. "PAC" is the three-character pricing action code (PAC). It explains the method of pricing. In this example, the "170" means providers will be paid at the lesser of the billed amount or maximum allowable fee indicated.

   Another PAC, 11J, indicates a medical consultant must review the service individually and determine coverage and reimbursement.

   The index key at the beginning of the DME Index/maximum allowable fee (MAF) report lists and explains all PACs.

4. "Max fee" is the maximum allowable fee, in dollars, paid to providers. For procedure code L3938, the MAF is $47.04.

5. "Eff date" is the date of service on or after which the MAF applies. In this example, July 1, 1998, is the effective date.

6. "Full desc" is the complete description of the procedure code. The description for L3938 is: "WHFO; wrist extension cock-up; dorsal wrist."

7. "POS" codes are place of service (POS) codes. These indicate where a procedure may be provided. For L3938, POS 0, 3, 4, 7, and 8 are the allowable places of service. See the index key at the beginning of the DME Index/MAF report for a description of all place of service codes.

8. "Prov types" indicates the valid provider types for a procedure code. For procedure code L3938, the provider types 26, 34, 35, 38, 44, 54, 58, 65, and 24 are valid. See the key at the beginning of the DME Index/MAF report for a description of provider types.

9. "BI" is the bilateral indicator. The "Y" means procedure code L3938 may be billed singly or as a pair. An "N" would mean the item may not be billed as bilateral.

10. "PA REQ" indicates when prior authorization (PA) is needed. The "N" in this example means the initial purchase of the item does not require PA.

    There are also several other indicators for this field. They can indicate PA is required for rental of an item beyond a specific number of days or PA is required if the billed amount exceeds a specific dollar amount. See the index key at the beginning of the DME Index/MAF report for a description of these indicators.

11. "Life exp" indicates the expected life of the item. Prior authorization is required if the item needs to be replaced before the end of its expected life. For procedure code L3938, the life expectancy is one year.

12. In the "NH" field, an "R" indicates the item may be separately billed to Wisconsin Medicaid for nursing home recipients.

13. "Copay" is the dollar amount that providers are to collect from recipients on each DME item purchased. In this example, the copayment is $2.00. Copayments are not to be collected from recipients on rented items.

    Refer to Section IV of Part A, the all-provider handbook, for more information on recipient copayments.

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Attachment 2a

Sample Prior Authorization Request Form (for custom orthotic)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 0750456

1 PROCESSING TYPE: 140

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER	4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
1234567890	XYZ Nursing Home 510 Willow Street Anywhere, WI 12345
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.	
5 DATE OF BIRTH MM/DD/YY	6 SEX M ☐ F ☒
	8 BILLING PROVIDER TELEPHONE NUMBER (xxx)xxx-xxxx
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. OTR Provider 123 Elm Street Anwhere, WI 12345	9 BILLING PROVIDER NO. 12345678
	10 DX: PRIMARY (L) CVA (R) Hemiparesis 438.21
	11 DX: SECONDARY Alzheimer's Dementia
	12 START DATE OF SOI: N.A.
	13 FIRST DATE RX: N.A.

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
L3999		8	P	Custom wrist with thumb hole, cock-up orthotic	1	xx.xx (charge itemized on section H of DMEA)
					TOTAL CHARGE	21 xx.xx

22. 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 the 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 Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 *I. M. Provider, OTR effective MM/DD/YY* (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE | EXPIRATION DATE | PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

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Attachment 2b

Sample Prior Authorization Durable Medical Equipment (for custom orthotic)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	88

PROVIDER INFORMATION

(6) PRESCRIBING PHYSICIAN'S NAME	(7) PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) (therapist's telephone number) DISPENSING PROVIDER'S TELEPHONE NUMBER
I. M. Provider	12345678	(xxx) xxx-xxxx

Attach Prescription

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Dependent in all self care. Had C.V.A. MM/DD/YY. M.D. notes "contractures evolving." Referred to O.T. and P.T. for R.O.M., strengthening R leg and arm.

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Received resting pan orthotic during hospitalization for C.V.A. MM/YY. The orthotic is causing fingers to be pushed into extension, leading to flexion of the wrist. A thumb-hole wrist cock-up orthotic is needed to prevent further contractures of fingers and wrist. Pain in the digits and wrist may be reduced or avoided with application of this orthotic. She currently cries out or grimaces with passive R.O.M. 1/2 to 3/4 of each time she is ranged.

C. Is the recipient able to operate the equipment/item requested — ☐ Yes ☒ No — If not, who will do this?

Nursing has been present during therapy to learn orthotic application. Wearing schedule is established and in chart and patient's room.

D. Is training provided or required? ☒ Yes ☐ No Explain:

Nursing will be applying orthotic.

E. State where equipment/item will be used:

☐ Home (Describe type of dwelling and accessibility)

☐ Nursing Home X ☐ School ☐ Office ☐ Job

(Describe accessibility and any special needs)

F. Attach an Occupational or Physical Therapy Report if available. Comprehensive evaluation is attached on separate sheet.

G. State estimated duration of need:

Ongoing.

H. If renewal or continuation of DME Authorization is requested, describe the recipient's

- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

L3999: *Note: This is a custom-fabricated orthotic, made from a pattern and formed to the specific patient.

P.R.O.M. measurements of R wrist/fingers MM/DD/YY.

			Index	Middle	Ring	Little finger
wrist extension neutral						
wrist flexible	WFL	flex. MCP	60	50	55	45
		PIP	55	55	60	75
Thumb MCP	40	DIP	20	35	25	45
IP	50					

Evaluation — amount of time — $xx.xx
Fitting — amount of time — $xx.xx
Materials — describe and itemize — $xx.xx
Follow-up — amount of time — $xx.xx

total cost (insert at element 20 of PA/RF)

I. Indicate amount of oxygen to be administered: N.A.

____ Liters per minute ____ Continuous
____ Hours per day ____ PRN
____ Days per week ____ PaO_2

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by EDS.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. MM/DD/YY I. M. Provider, OTR

Date Requesting Provider's Signature

Attachment 3a

Sample Prior Authorization Request Form (for therapy)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 0750456

1 PROCESSING TYPE
112

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
XYZ Nursing Home
510 Willow Street
Anywhere, WI 12345

5 DATE OF BIRTH
MM/DD/YY

6 SEX
M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER
(xxx) xxx-xxxx

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I. M. OTR Provider
c/o ABC Rehab Agency
123 Elm Street
Anwhere, WI 12345

9 BILLING PROVIDER NO.
12345678

10 DX: PRIMARY
Contracture, Hand 718.44

11 DX: SECONDARY
Late effects CVA 438

12 START DATE OF SOI:
N.A.

13 FIRST DATE RX:
N.A.

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
97003	OT	8	9	Evaluation	1	xx.xx
97139	OT	8	9	Fit / Follow-up / Positioning	1	xx.xx
					TOTAL CHARGE	21 xx.xx

22. 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 the 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 Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY
DATE

24 *I. M. Provider, OTR effective MM/DD/YY*
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

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Attachment 3b

Sample Prior Authorization Therapy Attachment

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT
(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Im	A	1234567890	56

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I. M. Provider, OTR	12345678	(xxx) xxx -xxxx

⑨ REFERRING/PRESCRIBING PHYSICIAN'S NAME: I. M. Referring, MD

A. Requesting: ☐ Physical Therapy ☒ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested 60 min. evaluation; 30 min. follow-up

Total Sessions per week requested 1

Total number of weeks requested 2

C. Provide a description of the recipient's diagnosis and problems including date of onset.

Late effects of C.V.A. Resultant (L) wrist/digital contractures. C.V.A. 02/92; contractures noted 07/97; progression of contractures 04/98.

D. Brief Pertinent History:

Im A. Recipient has been a resident of XYZ Nursing Home since 02/01/92, following a (R) C.V.A. c (L) Hemiparesis. She had several months of therapy at that time. On 07/97 she received O.T. for splinting of LUE. Screening and observation 04/98 by therapy and nursing indicate absence of orthotic and progression of contractures. Preferred not to wear hard orthotic.

Prior functional level 07/23/97 upon dc. from O.T.
Receives maximum assist for all ADLs; w/c bound but self propels. Fitted for orthotic of (L) wrist and digits—fits adequately and restorative nursing instructed during patient treatment. Had a 45-degree flexion contracture of wrist.

E. Therapy History:

	Location	Date	Problem Treated
PT	XYZ Nursing Home	02/20/92- 06/30/92	Ambulation—use of walker and w/c for distance Strengthening—LLE Range of motion—LLE Balance/Endurance transfer
OT	XYZ Nursing Home	02/20/92 08/01/92	Range of Motion— LUE Strengthening and coordination ADL—dressing, hygiene, eating
	XYZ Nursing Home	07/08/97- 07/23/97	Splinting— (L) contractures wrist/digits
SP	NA		

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)

Motor Evaluation 05/08/98

	LUE AROM	PROM	RUE
Shoulder flexion	0°-70°	0°-120°	AROM WFL throughout. Good strength throughout. Grasp 21#.
Shoulder abduction	0°-40°	0°-70°	
Elbow flexion	95°-120°	60°-135°	
Wrist flexion	contracture @ 90°	can be brought to 0° passively	

Left Digits:

Thumb: intact
Index: MP@ 90 degrees
Middle: MP @ 90 degrees
Ring: MP @ 100 degrees
Little: MP@ 110 degrees
PIPs and DIPs - WNL

ADL Evaluation 05/08/98

Maximum assist for dressing and hygiene. Feeds self about 1/4 of meal; appetite is poor; staff feeds remainder of meal. Mobility—propels self at times; ambulates short distances with restorative aids.

Tried soft flexion splint during O.T. evaluation and adjusted the wrist bar - appeared to work well. Gave instructions to staff and Im A. Recipient agreed to wear this orthotic.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

N. A.

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1. Order/manipulate soft orthotic to L.U.E. to accommodate (L) wrist/digital contractures →2 weeks. (97139)

Outcome: Prevent further contracture development L.U.E.

Note: Orthotic is reimbursed as part of the nursing home rate and will not be billed as DME.

2. As orthotic is being fit and positioning observed, instruct restorative nursing at same time re: wearing schedule and pressure points.

I. Rehabilitation Potential:

As Im A. Recipient has agreed to wear soft orthotic and since it feels more comfortable, prevention of further contracture of (L) wrist/and digits appears possible.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. I. M. Referring, M.D.
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

I. M. Provider, OTR
Signature of Therapist Providing Treatment

MM / DD / YY
Date

MM / DD / YY
Date

Attachment 4a

Sample Prior Authorization Request Form (for serial splinting)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 0750456

1 PROCESSING TYPE: 140

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890	4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): My private home, Apt. #2, 510 Willow Street, Anywhere, WI 12345
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.	
5 DATE OF BIRTH: MM/DD/YY; 6 SEX: M [X] F [ ]	8 BILLING PROVIDER TELEPHONE NUMBER: (xxx) xxx-xxxx
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. OTR Provider, 123 Elm Street, Anwhere, WI 12345	9 BILLING PROVIDER NO.: 12345678
	10 DX: PRIMARY: C. P. 343.9
	11 DX: SECONDARY:
	12 START DATE OF SOI: N.A.; 13 FIRST DATE RX: N.A.

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
L3999		3	P	(R) Wrist, forearm custom orthotic	1	xx.xx
L3999		3	P	(R) Wrist, forearm custom orthotic	1	xx.xx
L3999		3	P	(R) Wrist, forearm custom orthotic	1	xx.xx
L3999		3	P	(R) Wrist, forearm custom orthotic	1	xx.xx
						(charge itemized on
						section H of DMEA)
					TOTAL CHARGE	21 xx.xx

22. 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 the 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 Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 *I. M. Provider, OTR effective MM/DD/YY for 6 months* (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

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Attachment 4b

Sample Prior Authorization Durable Medical Equipment (for serial splinting)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	31

PROVIDER INFORMATION

(6) PRESCRIBING PHYSICIAN'S NAME	(7) PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) (therapist's telephone number) DISPENSING PROVIDER'S TELEPHONE NUMBER
I. M. Provider	12345678	(xxx) xxx-xxxx

Attach Prescription

Initial evaluation 02/04/98

Re-evaluation 06/17/98

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Mobility: Power wheelchair

Self-care: Dependent in all except eating and light hygiene. Eating requires moderate assistance with adaptive equipment. Light hygiene requires moderate assistance with adaptations (e.g., hand brush, suction soap dish, wash mitt).

Strength: Poor strength and endurance—minimal functional use of extremities (see above and attached evaluations).

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Diagnosis: C.P., spastic quadriplegia.

Pain in R UE, primarily in wrist and hand secondary to flexion of hand at x degrees and ulnar deviation of x degrees. Possible pressure on ulnar and/or median nerve. Decreased pain when brought into neutral position, but is unable to maintain due to hypertonia and spasticity.

A.R.O.M. is limited to: Shoulder Elbow Wrist Fingers Thumb

PLAN: Series of 3-4 orthotics over 6 months, gradually attempting to bring wrist to neutral position to relieve pain and increase ability to eat with minimal assistance and adaptive equipment and perform light hygiene with minimal assistance and adaptive equipment.

C. Is the recipient able to operate the equipment/item requested — ☐ Yes ☒ No — If not, who will do this?

Orthotic will be applied by parents or work staff after instruction and demonstration by therapist. Wearing schedule will be provided.

D. Is training provided or required? ☒ Yes ☐ No Explain:

Initial training of parents and work staff to position wrist and forearm correctly for orthotic application—also instruction regarding pressure area checks and wearing time.

E. State where equipment/item will be used:

☒ **Home (Describe type of dwelling and accessibility)**

☐ **Nursing Home** ☐ **School** ☐ **Office** ☒ **Job**

(Describe accessibility and any special needs)

F. Attach an Occupational or Physical Therapy Report if available. Comprehensive clinical initial evaluation, including R.O.M., strength, coordination, endurance, ADL, cog., sensory status attached.

G. State estimated duration of need:

Use of orthotic indefinitely - serial splinting only 6-8 months until desired results achieved.

H. If renewal or continuation of DME Authorization is requested, describe the recipient's

- **Current clinical condition**
- **Progress (improvement; no change, etc.)**
- **Results**
- **Recipient's use of equipment/item prescribed**

Approximately 3-4 orthotics will be used for a maximum of 6-8 months.

Each orthotic includes:

Re-evaluation	— amount of time	— $xx.xx
Fitting/fabrication	— amount of time	— $xx.xx
Materials	— describe and itemize	— $xx.xx
Follow-up	— amount of time	— $xx.xx

total cost (insert at element 20 of PA/RF)

I. Indicate amount of oxygen to be administered: N.A.

____ **Liters per minute**	____ **Continuous**
____ **Hours per day**	____ **PRN**
____ **Days per week**	____ **PaO_2**

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by EDS.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. MM/DD/YY — **Date**

I. M. Provider, OTR — **Requesting Provider's Signature**

Attachment 5
Prior Authorization and Billing Guide for Orthotics

Some Common Splinting Procedure Codes	Claim Amount	PA Required?	Billing Requirements
L3936 (WHFO; wrist extension cock-up; palmer) or L1930 (AFO, plastic)	Any	No, unless providing more frequently than the orthotic's life expectancy	--Paper (HCFA 1500) or electronic form is acceptable. --Use claim sort indicator "D." --When billing bilateral appliances for the same date of service, indicate a quantity of "2" or more in element 24G of the HCFA 1500 claim form. --When billing bilateral appliances for different dates of service, indicate modifier "01" and a quantity of "1" with the procedure code of the additional appliance billed. If the modifier is not indicated with the additional claim, the additional service will be denied.
L3999 (upper limb orthosis, not otherwise specified) or L2999 (lower extremity orthoses, not otherwise specified)	Less than $150	No	--Must bill using paper HCFA 1500 claim form. --Note the type of orthotic in element 19. --Use claim sort indicator "D." --When billing bilateral appliances for the same date of service, indicate a quantity of "2" or more in element 24G of the HCFA 1500 claim form. --When billing bilateral appliances for different dates of service, indicate modifier "01" and a quantity of "1" with the procedure code of the additional appliance billed. If the modifier is not indicated with the additional claim, the additional service will be denied.
L3999 (upper limb orthosis, not otherwise specified) or L2999 (lower extremity orthoses, not otherwise specified)	More than $150	Yes Submit PA/RF and PA/DMEA	--Must bill using paper HCFA 1500 claim form. --Must include modifier assigned on the PA (11-35). --Use claim sort indicator "D." --When billing bilateral appliances for the same date of service, indicate a quantity of "2" or more in element 24G of the HCFA 1500 claim form. --When billing bilateral appliances for different dates of service, indicate modifier "01" and a quantity of "1" with the procedure code of the additional appliance billed. If the modifier is not indicated with the additional claim, the additional service will be denied.
L4210 (Repair of orthotic device, repair or replace minor parts)	Less than $150	No	--Use a paper HCFA 1500 claim form. --Use claim sort indicator "D."
L4210 (Repair of orthotic device, repair or replace minor parts)	More than $150	Yes	--Use a paper HCFA 1500 claim form. --Use claim sort indicator "D." --Explain the type of repair in element 19.

PA: prior authorization