All Provider

Prior Authorization

ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

Certification and Ongoing Responsibilities
• Certification and recertification. • Change of address or status. • Documentation requirements. • Noncertified providers. • Ongoing responsibilities. • Provider rights. • Provider sanctions. • Recipient discrimination prohibited. • Release of billing information.

Claims Information
• Follow-up procedures. • Good Faith claims. • Preparing and submitting claims. • Reimbursement information. • Remittance information. • Submission deadline. • Timely filing appeals requests.

Coordination of Benefits
• Commercial health insurance. • Crossover claims. • Medicare. • Other Coverage Discrepancy Report, HCF 1159. • Primary and secondary payers. • Provider-based billing.

Covered and Noncovered Services
• Collecting payment from recipients. • Covered services. • Emergency services. • HealthCheck "Other Services." • Medical necessity. • Noncovered services.

Informational Resources
• Electronic transactions. • Eligibility Verification System. • Maximum allowable fee schedules. • Forms. • Medicaid Web site. • Professional relations representatives. • Provider Services. • Publications.

Managed Care
• Covered and noncovered HMO and SSI MCO services. • Enrollee HMO and SSI MCO eligibility. • Enrollment process. • Extraordinary claims. • HMO and SSI MCO claims submission. • Network and non-network provider information. • Provider appeals.

Prior Authorization
• Amending prior authorization (PA) requests. • Appealing PA decisions. • Grant and expiration dates. • Prior authorization for emergency services. • Recipient loss of eligibility during treatment. • Renewal requests. • Review process. • Submitting PA requests.

Recipient Eligibility
• Copayment requirements. • Eligibility categories. • Eligibility responsibilities. • Eligibility verification. • Identification cards. • Limited benefit categories. • Misuse and abuse of benefits. • Retroactive eligibility.

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Preface

This All-Provider Handbook is issued to all Medicaid-certified providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of this handbook for information about state-contracted managed care organizations.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/*.
- *dhfs.wisconsin.gov/badgercare/*.

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

General Information

Prior authorization (PA) is the electronic or written authorization issued by Wisconsin Medicaid to a provider prior to the provision of a service.

Prior authorization (PA) is the electronic or written authorization issued by Wisconsin Medicaid to a provider prior to the provision of a service. In most cases, providers are required to obtain PA *before* providing services that require PA.

Only about four percent of all services covered by Wisconsin Medicaid require PA. Prior authorization requirements vary for different types of services. Consequently, providers should refer to their service-specific publications and HFS 107, Wis. Admin. Code, for services requiring PA.

When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. Prior authorization requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may refer to the Medicaid Web site or call Provider Services at (800) 947-9627 or (608) 221-9883.

Reasons for Prior Authorization

According to HFS 107.02(3)(b), Wis. Admin. Code, PA is designed to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and recipients.

Wisconsin Medicaid processes PA requests based on criteria established by the Department of Health and Family Services. Refer to the Prior Authorization Review Process chapter of this section for more information.

Prior Authorization Does Not Guarantee Reimbursement

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The recipient is eligible for the service on the date the service is provided.
- The provider is certified by Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider failed to meet other program requirements.

Providers may not collect payment from a recipient for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the recipient did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

Refer to the Covered and Noncovered Services section of this handbook for information about situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from Wisconsin Medicaid for Medicaid-covered services that require PA when recipients have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, Wisconsin Medicaid will not consider backdating a PA request solely to enable the provider to be reimbursed.

Prior Authorization Requests

Depending on the service being requested, most PA requests must be comprised of the following:

- The Prior Authorization Request Form (PA/RF), HCF 11018. (Instead of the PA/RF, dental providers are required to submit the Prior Authorization Dental Request Form [PA/DRF], HCF 11035, and hearing instrument specialists and audiologists use the Prior Authorization Request for Hearing Instrument and Audiological Services [PA/HIAS1] form, HCF 11020, for hearing instruments and related services.)
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Providers should refer to service-specific publications and the Medicaid Web site for service-specific PA requirements and PA forms and attachments.

Prior Authorization Request Form

The PA/RF is used by Wisconsin Medicaid and is mandatory for most providers when requesting PA. The PA/RF (PA/DRF or PA/HIAS1) serves as the cover page of a PA request.

Providers are required to complete the basic provider, recipient, and service information on the PA/RF (PA/DRF or PA/HIAS1). Each PA request is assigned a unique seven-digit number. This PA number must be indicated on a claim for the service because it identifies the service as one that has been prior authorized.

Service-Specific Prior Authorization Attachment

In addition to the PA/RF (PA/DRF or PA/HIAS1), a service-specific PA attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for Wisconsin Medicaid to make a reasonable judgment about the case.

The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s).

Additional Supporting Clinical Documentation

Certain PA requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a physician's

prescription, clinical reports, and other materials related to the recipient's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the recipient's name, Medicaid identification number, and PA request number. Securely packaged X-rays and photographs will be returned to providers with the finalized PA request.

Most PA attachments can be downloaded and printed in their original format from the Forms page of the Medicaid Web site.

Prior Authorization Forms and Attachments

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, the form number, and number of forms desired and send the request to:

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

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Forms page of the Medicaid Web site. Many forms are available in fillable Portable Document Format (PDF) and fillable Microsoft® Word formats.

The PA/RF, PA/DRF, and PA/HIAS1 cannot be downloaded and printed in their original format from the Medicaid Web site because they are uniquely numbered multi-part forms. In addition, the Prior Authorization Request/ Hearing Instrument and Audiological Services (PA/HIAS2), HCF 11021, is not available in PDF format since it is also a multi-part form. Providers may order paper copies of these forms from Form Reorder at the previously listed address.

Web Prior Authorization

Certain providers may complete the PA/RF and PA attachments on the Medicaid Web site. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to Wisconsin Medicaid. Providers should refer to the Medicaid Web site for more information on Web PA.

Grant and Expiration Dates

Prior authorization requests are approved for varying periods of time based on the clinical justification submitted.

Grant Date

The grant (start) date of an approved or modified PA request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by Wisconsin Medicaid.

Expiration Date

The expiration (end) date of an approved or modified PA request is the date through which services are prior authorized. Prior authorization requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Backdating Requests

Backdating an initial PA request to a date prior to Wisconsin Medicaid's initial receipt of the

request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request is received by Wisconsin Medicaid within 14 calendar days of the start of the provision of services.

Providers should refer to their service-specific publications for differences in this standard policy.

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA requests (i.e., subsequent PA requests for ongoing services) must be received by Wisconsin Medicaid *prior to the expiration date* of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Discuss Prior Authorization with Recipients

Wisconsin Medicaid recommends that providers inform recipients that PA is required for certain specified services *before* delivery of the services. Providers should also explain that, if required, they will be submitting recipient records and information to Wisconsin Medicaid on the recipient's behalf to obtain PA. Providers are required to keep recipients informed of the PA request status throughout the *entire* PA process.

Recipient Questions About Prior Authorization Requests

A recipient may call Recipient Services at (800) 362-3002 or (608) 221-5720 to find out whether or not a PA request has been submitted and, if so, when it was received by Wisconsin Medicaid. The recipient will be advised to contact the provider if more information is needed about the status of individual PA requests.

Emergency Services

In emergency situations, the PA requirement may be waived for services that normally require PA. Emergency services are defined in HFS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all Medicaid-covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the recipient, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Refer to the Covered and Noncovered Services section of this handbook for more information about program requirements.

Urgent Services

Telephone consultations with Medicaid staff regarding a prospective PA request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the recipient or unnecessary costs for Wisconsin Medicaid

To prevent a lapse in coverage or lapse in reimbursement for ongoing services, all renewal PA requests (i.e., subsequent PA requests for ongoing services) must be received by Wisconsin Medicaid *prior to the expiration date* of the previous PA request.

Prior authorization may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a recipient attain or regain his or her health and ability to function independently.

as determined by the Division of Health Care Financing (DHCF). All telephone consultations for urgent services should be directed to the DHCF's Bureau of Health Care Program Integrity at (608) 266-2521. Providers should have the following information ready when calling:

- Recipient's name.
- Recipient's Medicaid identification number.
- Service(s) needed.
- Reason for the urgency.
- Diagnosis of the recipient.
- Procedure code of the service(s) requested.

Providers are required to submit a PA request to Wisconsin Medicaid within 14 calendar days after the date of the telephone consultation. Prior authorization may be denied if the request is received more than two weeks after the consultation. If the PA request is denied in this case, the provider cannot request payment from the recipient.

Prior Authorization for HealthCheck "Other Services"

HealthCheck is a program that provides Medicaid-eligible children under age 21 with regular health screenings. Refer to HealthCheck publications for the types of providers and agencies eligible for HealthCheck screener certification.

Certain medically necessary services not otherwise covered by Wisconsin Medicaid may be covered to treat or ameliorate a condition identified in a HealthCheck screening. All such "Other Services," except for certain over-the-counter drugs identified in service-specific publications, must be prior authorized. Providers should refer to the Covered and Noncovered Services section of this handbook for more information on HealthCheck "Other Services," including PA instructions.

Referral to Out-of-State Providers

Prior authorization may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a recipient attain or regain his or her health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the recipient in Wisconsin.

Out-of-state providers are required to meet Wisconsin Medicaid's guidelines for PA approval.

The following table indicates the services that require PA when performed by out-of-state providers.

Prior Authorization Requirements for Out-of-State Providers

Provider	Services Requiring Prior Authorization*
All out-of-state nursing homes, regardless of location	All services
All other out-of-state non-border-status providers	All nonemergency services except home dialysis supplies and equipment

*Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (e.g., anesthesia report, medical record) to allow for reimbursement.

When a Wisconsin Medicaid provider refers a recipient to an out-of-state, noncertified provider, the referring provider should refer the out-of-state provider to the Wisconsin Medicaid Web site or Provider Services to obtain appropriate certification materials, PA forms, and claim instructions. The out-of-state provider is responsible for sending PA requests, required attachments, and supporting documentation to Wisconsin Medicaid before the services are provided.

Status Inquiries

Except in certain circumstances, decisions on PA requests are made within 20 working days from the receipt of *all* information necessary to process the request. (Most decisions are made within 10 working days.) Providers may inquire about the status of a PA request through one of the following methods:

- Accessing the Automated Voice Response system at (800) 947-3544 or (608) 221-4247.
- Calling Provider Services.

Providers should have the seven-digit PA number available when making inquiries.

For More Information

Providers should verify that they have the most current sources of information regarding PA. It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters HFS 101-109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43-49.499 provide the legal framework for Wisconsin Medicaid.
- Service-specific publications: Handbooks give detailed information about what services are covered for a provider type, what services require PA, and how to submit claims for services. *Wisconsin Medicaid and BadgerCare Updates* give the latest policy changes for all providers and for specific provider types.
- The Managed Care section of this handbook: This section is necessary for providers of services to any Medicaid managed care enrollees.

Providers should refer to the Medicaid Web site to obtain these materials or more information.

Except in certain circumstances, decisions on PA requests are made within 20 working days from the receipt of *all* information necessary to process the request.

Submitting Prior Authorization Requests

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to Wisconsin Medicaid.

Providers have the following options for submitting prior authorization (PA) requests:

- Mail.
- Fax.
- Specialized Transmission Approval Technology-Prior Authorization (STAT-PA).
- The Web.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to Wisconsin Medicaid.

Mailing Prior Authorization Requests

Any type of PA request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Faxing Prior Authorization Requests

Faxing PA requests to Wisconsin Medicaid may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should *not* fax the same PA request more than once.
- Providers should *not* fax *and* mail the same PA request. This causes delays in processing.

Prior authorization requests containing X-rays, dental molds, or photos as documentation may not be faxed; they must be mailed.

Providers may fax completed PA requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any other Wisconsin Medicaid fax number may result in delays. Providers should follow the procedures listed in Appendix 1 of this section when faxing PA requests.

To help safeguard the confidentiality of recipient health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet, HCF 1176, in Appendix 2 of this section includes a confidentiality statement and may be photocopied. The cover sheet may also be downloaded and printed from the Medicaid Web site.

STAT-PA

Providers can submit STAT-PA requests for a limited number of services (e.g., certain drugs, lead inspections for HealthCheck). The STAT-PA system is an automated system accessed by providers by touch-tone telephone that allows them to receive an immediate decision for certain PA requests. Information about STAT-PA is included in service-specific Medicaid publications, when applicable.

Web Prior Authorization

Wisconsin Medicaid accepts PA requests for many services via the Medicaid Web site. Completing and submitting PA requests via the Web is intended to reduce the number of requests returned to providers due to clerical errors or omissions and may establish initial grant dates according to current policy.

Providers should refer to the Medicaid Web site to determine whether they can submit PA requests via the Web.

Users may submit PA requests via the Web Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central time). Web PA is not available on weekends or state-observed holidays.

User Resources

If users have questions about submitting PA requests on the Web, Wisconsin Medicaid offers a complete online tutorial, online Help, a helpdesk, and representatives to assist providers submitting PA requests via the Web.

Online Tutorial

There is a complete tutorial for users who want step-by-step instructions on submitting PA requests via the Medicaid Web site. A Tutorial link is located at the top of each screen.

Online Help

If users have a question about a specific item while submitting a PA request (e.g., a procedure code element on the PA/RF), they may select "Help" at the top of the Web page. This will give the provider a brief explanation about a specific item.

Helpdesk

For help with logging in or other Web PA questions, users may also contact the Web PA technical helpdesk at (608) 221-9730. The helpdesk is available Monday through Friday from 8:30 a.m. to 4:30 p.m. (Central time).

Note: For PA policy questions, providers should contact Provider Services.

Users may submit PA requests via the Web Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central time).

Prior Authorization Review Process

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information.

The prior authorization (PA) review process includes a clerical review and a clinical review.

Clerical Review

The provider, recipient, diagnosis, and treatment information indicated on the Prior Authorization Request Form (PA/RF), HCF 11018, Prior Authorization Dental Request Form (PA/DRF), HCF 11035, and Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) form, HCF 11020, is reviewed during the clerical review of the PA review process. The following are examples of information verified during the clerical review:

- Medicaid billing and/or performing provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid certified.
- Procedure codes with appropriate modifiers, if required, are Medicaid-covered services.
- Recipient's name is spelled correctly.
- Recipient Medicaid identification number is correct and corresponds with the recipient's name.
- Recipient eligibility is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current physician's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a recipient, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs via the Medicaid Web site. Providers should refer to the Submitting Prior Authorization Requests chapter of this section for more information about Web PA.

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by Wisconsin Medicaid to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary" as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers the following when determining whether to approve or deny a PA request pursuant to HFS 107.02(3)(e), Wis. Admin. Code:

- The medical necessity of the service, as defined in HFS 101.03(96m), Wis. Admin. Code.
- The appropriateness of the service.
- The cost of the service.
- The frequency of furnishing the service.
- The quality and timeliness of the service.
- The extent to which less expensive alternative services are available.
- The effective and appropriate use of available services.
- The misutilization practices of providers and recipients.

- The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare or commercial health insurance guidelines.
- The need to ensure that there is close professional scrutiny for care that is of unacceptable quality.
- The flagrant or continuing disregard of established state and federal policies, standards, fees, or procedures.
- The professional acceptability of unproven or experimental care, as determined by consultants to the department.

It is crucial that a provider include adequate information on the PA attachment so that the Medicaid consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary," including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the recipient's current condition and needs. Providers should refer to their service-specific publications for instructions on how to complete the attachment appropriate to the service requested.

Medically Necessary Defined

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical. Pursuant to HFS 101.03(96m), Wis. Admin. Code, "medically necessary" is a service under ch. HFS 107 that meets the following:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:
    1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
    2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
    3. Is appropriate with regard to generally accepted standards of medical practice;
    4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
    5. Is of proven medical value or usefulness and, consistent with HFS 107.035, is not experimental in nature;
    6. Is not duplicative with respect to other services being provided to the recipient;
    7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
    8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
    9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the recipient's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, Medicaid consultants

It is crucial that a provider include adequate information on the PA attachment so that the Medicaid consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary," including elements that are not strictly medical in nature.

obtain direction and/or guidance from multiple resources including:

- Federal and state statutes.
- Wisconsin Administrative Code.
- Prior authorization guidelines set forth by the Department of Health and Family Services.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Follow-Up to Prior Authorization Decisions

Most PA decisions are made within 10 working days.

Except in certain circumstances, prior authorization (PA) decisions are made within 20 working days from the receipt of *all* information necessary to process the request. (Most PA decisions are made within 10 working days.)

Prior Authorization Decisions

After the clerical and clinical reviews are complete, the PA request is:

- Approved.
- Approved with modification.
- Denied.
- Returned to the provider for additional information or clarification.

Approved Requests

When a PA request for a service is approved, the provider will receive a copy of the PA request or a PA decision notice. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested *service*, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Modified Requests

Modification is a change in the services originally requested on a PA request.

Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified by Wisconsin Medicaid, both the provider and the recipient are notified. The provider receives a copy of the modified Prior Authorization Request Form (PA/RF), HCF 11018, Prior Authorization Dental Request Form (PA/DRF), HCF 11035, or Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) form, HCF 11020, from Wisconsin Medicaid, including the reason for PA modification. The recipient receives a "Notice of Appeal Rights" letter that includes a brief statement of the reason PA was modified and information on his or her right to a fair hearing. *Only the recipient, or authorized person acting on behalf of the recipient, can appeal the modification*. Refer to Appendix 3 of this section for a sample copy of the letter recipients receive.

Wisconsin Medicaid requires providers to discuss with the recipient the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the recipient does not appeal Medicaid's decision to modify the PA request or appeals Medicaid's decision but the decision is upheld and the recipient chooses to receive the originally requested service anyway, the recipient may choose to receive the service(s) as a noncovered service. Refer to the Covered and Noncovered Services section of this handbook for information about situations when a provider may collect payment from a recipient for services for which PA was modified.

Providers may contact Wisconsin Medicaid by calling Provider Services for clarification of why a PA request was modified.

Returned Requests

A PA request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the PA/RF, PA/DRF, or PA/HIAS1, including attachments, are returned to the provider for correction. *Providers should resubmit the returned PA/RF, PA/DRF, or PA/HIAS1 all attachments, and the additional information that was requested by fax at (608) 221-8616 or to the following address:*

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

A new PA/RF, PA/DRF, or PA/HIAS1 should *not* be submitted because a new PA/RF, PA/DRF, or PA/HIAS1 would result in a later grant date and a new PA number.

Note: A returned PA request is *not* a denied PA request.

As stated in HFS 107.02(3)(a), Wis. Admin. Code, the provider is required to notify the recipient of the reason for the delay.

Denied Requests

When a PA request is denied by Wisconsin Medicaid, both the provider and the recipient are notified. The provider receives a copy of the denied PA/RF, PA/DRF, or PA/HIAS1, or a PA decision notice from Wisconsin Medicaid, including the reason for PA denial. The recipient receives a "Notice of Appeal Rights" letter that includes a brief statement of the reason PA was denied and information about his or her right to a fair hearing. Only the *recipient or authorized person acting on behalf of the recipient* can appeal the denial. (Refer to "Appealing a Decision" in this chapter for more information.)

Providers may contact Wisconsin Medicaid by calling Provider Services for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the recipient and are encouraged to help the recipient understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a *new* PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF, PA/DRF, or PA/HIAS1.
- Provide the service as a noncovered service.

If the recipient does not appeal Medicaid's decision to deny the PA request or appeals Medicaid's decision but the decision is upheld and the recipient chooses to receive the service anyway, the recipient may choose to receive the service(s) as a noncovered service. Refer to the Covered and Noncovered Services section of this handbook for information about situations when a provider may collect payment from a recipient for services for which PA was denied.

Providers are required to discuss a denied PA request with the recipient and are encouraged to help the recipient understand the reason the PA request was denied.

Requesting Amendments

A request to amend a PA request may be submitted by fax or mail to Wisconsin Medicaid and must be received by Wisconsin Medicaid *before* the expiration date of the PA request to be amended.

If a PA request is denied or modified by Wisconsin Medicaid, only a recipient, or authorized person acting on behalf of the recipient, may file an appeal with the Division of Hearings and Appeals (DHA).

Examples of when providers may request an amendment to an approved or modified PA request include the following:

- To temporarily modify a recipient's frequency of a service when there is a short-term change in his or her medical condition.
- To change the performing provider information when the billing provider remains the same.
- To change the recipient's Medicaid identification number.
- To add or change a procedure code.

Note: Wisconsin Medicaid recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Amendment requests should include the following:

- A Prior Authorization Amendment Request form, HCF 11042. The completion instructions and Prior Authorization Amendment Request form are located in Appendices 4 and 5 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.
- A copy of the PA/RF, PA/DRF, or PA/HIAS1 to be amended (*not* a new PA/RF, PA/DRF, or PA/HIAS1).
- Additional supporting materials (medical documentation) explaining or justifying the requested changes.

Enddating a Prior Authorization Request

Examples of when a PA request should be enddated include the following:

- A recipient chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a recipient's continual care services.
- There is a change in the recipient's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

To enddate a PA request, send the following information to Wisconsin Medicaid:

- A letter asking for the PA request to be enddated. (Providers may submit a Prior Authorization Amendment Request form instead of a letter.)
- A copy of the PA/RF, PA/DRF, or PA/HIAS1, if possible.
- The requested enddate.

Appealing a Decision

If a PA request is denied or modified by Wisconsin Medicaid, only a recipient, or authorized person acting on behalf of the recipient, may file an appeal with the Division of Hearings and Appeals (DHA). Decisions that may be appealed include:

- Denial or modification of a PA request.
- Denial of a retroactive authorization for a service.

The recipient is required to file an appeal within 45 days of the date of the "Notice of Appeal Rights" letter from Wisconsin Medicaid. Refer to Appendix 3 of this section for a sample of this letter.

To file an appeal, recipients may complete and submit a Request for Fair Hearing form, DHA-28. The Request for Fair Hearing form may be downloaded and printed from the Recipient page of the Medicaid Web site.

Though providers cannot file an appeal, they are encouraged to remain in contact with the recipient during the appeal process. Providers may offer the recipient information necessary to file an appeal and help present his or her case during a fair hearing.

Fair Hearing Decision Upholds Medicaid's Decision

If the hearing decision upholds Medicaid's decision to deny or modify a PA request, the DHA notifies the recipient and Wisconsin Medicaid in writing. The recipient may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns Medicaid's Decision

If the hearing decision overturns Medicaid's decision to deny or modify the PA request, the DHA notifies Wisconsin Medicaid, the recipient, and the provider. The letter includes instructions for the provider and for Wisconsin Medicaid.

If the DHA letter instructs the provider to submit a claim for the service, the provider should submit the following to Wisconsin Medicaid after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim.
- A copy of the hearing decision.
- A copy of the denied PA request.

Providers are required to submit claims with hearing decisions to the following address:

Wisconsin Medicaid
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Claims with hearing decisions sent to any other Medicaid address may not be processed appropriately.

If the DHA letter instructs the provider to submit a *new* PA request, the provider is required to submit the new PA request along with a copy of the hearing decision to the PA Unit at the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Wisconsin Medicaid will then approve the PA request with the revised process date. The provider may then submit a claim following the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the recipient asks to receive the service *before* the hearing decision is made, the provider is required to notify the recipient before rendering the service that the recipient will be responsible for payment if Medicaid's decision to deny or modify the PA request is upheld.

If the recipient accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *upholds* Medicaid's decision to deny or modify the PA request, the provider may collect payment from the recipient if certain conditions are met. Refer to the Covered and Noncovered Services section of this handbook for more information.

Providers may offer the recipient information necessary to file an appeal and help present his or her case during a fair hearing.

Wisconsin Medicaid does not directly reimburse recipients.

If the recipient accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *overturns* Medicaid's decision to deny or modify a PA request, the provider may submit a claim to Wisconsin Medicaid. If the provider collects payment from the recipient for the service before the appeal decision is overturned, the provider is required to refund the recipient for the *entire* amount of payment received from the recipient after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse recipients.

Situations Requiring a New Prior Authorization Request

Examples of when a new prior authorization (PA) request must be submitted include:

- A provider's Medicaid billing provider number changes.
- A recipient requests a provider change that results in a change in billing providers.

If the *performing* provider indicated on the PA request changes but the *billing* provider remains the same, the PA request remains valid and a new PA request does *not* need to be submitted.

Refer to the Certification and Ongoing Responsibilities section of this handbook for the definitions of performing provider and billing provider.

If the *performing* provider indicated on the PA request changes but the *billing* provider remains the same, the PA request remains valid and a new PA request does *not* need to be submitted.

Change in Billing Providers

Providers are required to submit a new PA request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and Medicaid billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same recipient, the same service(s), and the same dates, the new billing provider is required to send the following to Medicaid's PA Unit:

- A copy of the existing PA request, if possible.
- A new PA request, including the required attachments and supporting documentation indicating the new billing provider's name and address and billing provider number.
- A letter requesting the enddating of the existing PA request (may be a photocopy) attached to each PA request with the following information:
  - ✓ The previous billing provider's name and billing provider number, if known.
  - ✓ The new billing provider's name and billing provider number.
  - ✓ The reason for the change of billing provider. (The provider may want to confer with the recipient to verify that the services by the previous provider have ended. The new billing provider may include this verification in the letter.)
  - ✓ The requested effective date of the change.

Services Not Performed Before Expiration Date

Generally, a new PA request with a new requested start date must be submitted to Wisconsin Medicaid if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary. Providers should refer to their service-specific publications for more information about requirements for services not performed before the expiration date.

Recipient Eligibility Changes

Retroactive Eligibility

If a service(s) that requires prior authorization (PA) was performed during a recipient's retroactive eligibility period, the provider is required to submit a PA request and receive approval from Wisconsin Medicaid *before* submitting a claim. Providers should indicate the words "RETROACTIVE ELIGIBILITY" at the top of the PA request or in the "Description of Service" element. In addition, providers should explain that the service was provided at a time when the recipient was retroactively eligible and include the actual date(s) the service(s) was provided.

If a service(s) that requires prior authorization (PA) was performed during a recipient's retroactive eligibility period, the provider is required to submit a PA request and receive approval from Wisconsin Medicaid *before* submitting a claim.

If the recipient was retroactively eligible and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the recipient receives retroactive eligibility. If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the service(s). Recipients have the right to appeal Medicaid's decision to deny a PA request. Refer to the Prior Authorization Decisions chapter of this section for more information about appeal procedures.

If a recipient requests a service that requires PA before his or her retroactive eligibility is determined, the provider should explain to the recipient that he or she may be liable for the full cost of the service if retroactive eligibility is not granted and the PA request is not approved. This should be documented in the recipient's record.

Refer to the Recipient Eligibility section of this handbook for more information about retroactive eligibility.

Recipient Loss of Eligibility During Treatment

Some Medicaid-covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a recipient loses Medicaid eligibility midway through treatment or any time between the grant and enddates, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided during an eligibility lapse.

Exceptions to the loss-of-eligibility midway-through-treatment rule are if a recipient becomes ineligible while receiving dental prosthodontia treatment or orthodontic treatment. Dentists should refer to dental publications for more detailed information.

Other providers should not assume Wisconsin Medicaid covers completion of services after the recipient's eligibility has ended or changed.

To avoid potential reimbursement problems when a recipient loses eligibility during treatment, providers should follow these procedures:

- Ask to see the recipient's identification card to verify the recipient's eligibility or consult the Medicaid Eligibility Verification System before the services are provided at each visit.
- When the PA request is approved, verify that the recipient is still eligible for Wisconsin Medicaid and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the eligibility of the recipient.

Recipients are financially responsible for any services received after their Wisconsin Medicaid eligibility has ended, except for dental prosthodontia and orthodontic treatment. If the recipient wishes to continue treatment, it is a decision between the provider and the recipient whether the service should be given and how payment will be made for the service.

To avoid misunderstandings, providers should remind recipients that they are financially responsible for any continued care after their eligibility ends.

Recipients Retroactively Disenrolled from State-Contracted Managed Care Organizations

Occasionally, a service requiring Medicaid fee-for-service PA is performed during a recipient's enrollment period in a state-contracted managed care organization (MCO). After the service is provided and it is determined that the recipient should be retroactively disenrolled from the MCO, the recipient's eligibility is changed to fee-for-service for the DOS. The recipient is continuously eligible for Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the recipient was not enrolled on the DOS. Medicaid fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service recipients, the provider is required to submit a retroactive PA request. Indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the service requested/ provided under "Description of Service" on the PA request. Also indicate the actual date(s) the service(s) was provided.
- If the PA request is approved, the provider is required to follow Medicaid's fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the recipient.

Recipients are financially responsible for any services received after their Wisconsin Medicaid eligibility has ended, except for dental prosthodontia and orthodontic treatment.

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 1

Prior Authorization Fax Procedures

Providers may fax prior authorization (PA) requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any Wisconsin Medicaid fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to Wisconsin Medicaid, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission.
- Number of pages, including the cover sheet. The Medicaid fax clerk will contact the provider by fax or telephone if all the pages do not transmit. (Refer to "Incomplete Fax Transmissions" of this appendix for instructions if the pages do not all transmit.)
- Provider contact person and telephone number. The Wisconsin Medicaid fax clerk may contact the provider with any questions about the fax transmission.
- Wisconsin Medicaid provider identification number.
- Fax telephone number to which Wisconsin Medicaid may send its adjudication decision.
- To: "Wisconsin Medicaid Prior Authorization."
- Wisconsin Medicaid's fax number ([608] 221-8616). Prior authorization requests sent to any other Wisconsin Medicaid fax number may result in processing delays.
- Wisconsin Medicaid's telephone numbers. For specific PA questions, providers should call (800) 947-9627 or (608) 221-9883. For faxing questions, providers should call (608) 221-4746, **extension 3064***

***Extension 3064 is no longer valid. Please use extension 80118, effective immediately.**

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (i.e., pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission) or if the PA request is missing information, providers will receive the following by fax from the Medicaid fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that Wisconsin Medicaid received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the *entire* original fax transmission *and* the additional information requested by the fax clerk to (608) 221-8616.

General Guidelines

When faxing information to Wisconsin Medicaid, providers should not reduce the size of the Prior Authorization Request Form (PA/RF), HCF 11018, or the Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) form, HCF 11020, to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, Wisconsin Medicaid will mail the decision back to the provider.

Wisconsin Medicaid will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call Medicaid's fax clerk at (608) 221-4746, **extension 3064***, to inquire about the status of the fax.

***Extension 3064 is no longer valid. Please use extension 80118, effective immediately.**

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has *not* changed. All actions regarding PA requests are made within the time frames outlined in this handbook and service-specific publications.

Faxed PA requests received after 1:00 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should *not* send the original paperwork, such as the carbon PA/RF, by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Submitting New Prior Authorization Requests

Providers should not photocopy and reuse the same PA/RF for other requests. When submitting a *new* request for PA, it must be submitted on a new PA/RF so that the request is processed under a new PA number. This requirement applies whether the PA request is submitted by fax or by mail.

Response Back from Wisconsin Medicaid

Once Wisconsin Medicaid reviews a PA request, Wisconsin Medicaid will fax one of three responses back to the provider:

- "Your approved, modified, or denied Prior Authorization (PA) request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments, which includes Wisconsin Medicaid's 15-digit internal control number located on the top half of the PA/RF. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

Appendix 2
Prior Authorization Fax Cover Sheet

(A copy of the Prior Authorization Fax Cover Sheet is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
HCF 1176 (Rev. 08/05)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION FAX COVER SHEET

CONFIDENTIALITY: This facsimile transmission is intended only for the use of the individual or entity to whom it is addressed. It may contain information that is privileged, confidential, or exempt from disclosure under applicable law.

If the reader of this message is not the intended recipient, you are notified that any review, use, copying, or dissemination or distribution of the contents other than to the addressee of the communication is strictly prohibited.

If you received this communication in error, notify us immediately by telephone and return the original message to us through the United States Postal Service to the address we will provide.

TO		Date Sent
Name	Telephone Numbers	Fax Number
Wisconsin Medicaid Prior Authorization (PA)	**PA questions — (800) 947-9627 or (608) 221-9883** **Fax questions — (608) 221-4746, extension 3064**	**(608) 221-8616**

FROM (Sender)

Name — Provider Contact Person	Number of Pages Including This Cover Sheet	Fax Number
Wisconsin Medicaid Provider Number		Telephone Number

COMMENTS / INSTRUCTIONS

Appendix 3
Sample Notice of Appeal Rights Letter

(A sample Notice of Appeal Rights Letter is located on the following pages.)

(This page was intentionally left blank.)

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
dhfs.wisconsin.gov/

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

Notice of Appeal Rights

March 1, 2005

Mr. I.M. Recipient
609 Willow St.
Anytown WI 55555

MA ID#: 1234567890
County Social/
Human Service Office: 608-123-4567
Appeal Date: 15 April 2005

Dear Mr. Recipient:

In the Wisconsin Medicaid Program, certain services and products must be reviewed and approved before payment can be made for them. This review process is called Prior Authorization (PA). The purposes of this letter are to notify you that Wisconsin Medicaid has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf, and to inform you of your right to appeal that decision.

Your provider Anytown Home Health Services requested prior authorization for the following:

99600 Unlisted home visit service or procedure (per visit)
97799 Unlisted physical medicine/rehabilitation service or procedure (per visit)

That prior authorization request, PA number 1234567, was reviewed by Wisconsin Medicaid medical consultants. Based on that review, the following services have been denied or modified as follows:

Denied Services:

97799 Unlisted physical medicine/rehabilitation service or procedure (per visit)

Modified Services:

99600 Unlisted home visit service or procedure (per visit)

Wisconsin Medicaid's denial or modification of the services requested was made for the following reasons:

Service(s) do not meet Medical Assistance guidelines.
You can receive the care you need during the visits approved.

Wisconsin Medicaid bases its decisions on criteria found in the Wisconsin Administrative Code. Wisconsin Medicaid may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that support the reason for the denial/modification of your provider's request for services is found in:

HFS 107.02(3)(e) In determining whether to approve or disapprove a request for prior authorization, the department shall consider: 1. The medical necessity of the service; 2. The appropriateness of the service; 3. The cost of the service; 4. The frequency of furnishing the service; 5. The quality and timeliness of the service; 6. The extent to which less expensive alternative services are available; 7. The effective and appropriate use of available services; 8. The misutilization practices of providers and recipients; 9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines; 10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality; 11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and 12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

HFS 107.02(3)(e) [General limitations: Prior authorization: Departmental review criteria] in determining whether to approve or disapprove a request for prior authorization, the department shall consider: 1. The medical necessity of the service; 2. The appropriateness of the service; 3. The cost of the service; 4. The frequency of furnishing the service; 5. The quality and timeliness of the service; 6. The extent to which less expensive alternative services are available; 7. The effective and appropriate use of available services; 8. The misutilization practices of providers and recipients; 9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines; 10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality; 11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and 12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

We have sent your provider the denied/modified prior authorization request. We encourage you to contact Anytown Home Health Services to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You, or your designated representative, may appeal this decision in accordance with state and federal law within 45 days. To file an appeal:

1) Call your County Social/Human Services office at the telephone number listed above for an appeal form and/or assistance in completing it,

or

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

Division of Hearings and Appeals
Department of Administration
P.O. Box 7875
Madison, WI 53707-7875

The appeal form or letter should include:

- the name, address, phone number of the Medicaid recipient for whom the appeal is being made
- the Medicaid identification number of the recipient
- the Prior Authorization number 1234567 of the denied/modified request
- the reason you think the denial or modification of the PA is wrong

REMEMBER: You must mail or deliver your appeal to your county Social/Human Services Office or the Division of Hearings and Appeals so it is received by the 45-day deadline, which is 15 April 2005.

You will lose your right to an appeal if your request to appeal is not received by the county Social/ Human Services Office or the Division of Hearings and Appeals by 15 April 2005.

If you file an appeal:

- The State Division of Health Care Financing will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal, and will notify you of the time and place by mail. Hearings are generally held at your county Social/Human Services office. You may want to ask your county agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc, to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Financing staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, the Medicaid program will pay for any services it has approved. After the hearing officer makes a decision on your appeal, Medicaid will continue to pay for the approved services plus any additional services the hearing officer directs Medicaid to pay.

If you need information about accommodation for a disability or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (TDD) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Medicaid's decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings & Appeals should only be used for questions about the hearing process.

Sincerely,

Chief Medical Officer
Division of Health Care Financing

Sincerely,

Chief Medical Officer
Division of Health Care Financing

Sincerely,

Bureau of Health Care Program Integrity
Division of Health Care Financing

Appendix 4

Prior Authorization Amendment Request Completion Instructions

(A copy of the Prior Authorization Amendment Request Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST 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. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Amendment Request to the Prior Authorization Request Form (PA/RF), HCF 11018, and physician's orders (within 90 days of the dated signature) and send it to Wisconsin Medicaid. 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 that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Today's Date
Enter today's date in MM/DD/YYYY format.

Element 2 — Previous Prior Authorization Number
Enter the seven-digit PA request number from the PA/RF to be amended. The request number is located in the top right section of the PA/RF.

Element 3 — Name — Recipient
Enter the recipient's name as indicated in Element 8 of the PA/RF, including recipient's last and first name and middle initial.

Element 4 — Recipient Medicaid Identification No.
Enter the ten-digit recipient Medicaid identification number as indicated in Element 5 of the PA/RF.

SECTION II — PROVIDER INFORMATION

Element 5 — Name — Billing Provider
Enter the billing provider's name as indicated in Element 1 of the PA/RF.

Element 6 — Billing Provider's Medicaid Provider No.
Enter the eight-digit billing provider's Medicaid provider number as indicated in Element 4 of the PA/RF.

Element 7 — Address — Billing Provider
Enter the billing provider's address (include street, city, state, and Zip code) as indicated in Element 1 of the PA/RF.

Element 8 — Amendment Effective Dates
Enter the dates that the requested amendment should start and end.

SECTION III — AMENDMENT INFORMATION

Element 9
Enter the reasons for requesting additional service(s) for the recipient.

Element 10
Enter the appropriate procedure code and hours per day and days per week, multiplied by the number of weeks for each service.

Element 11 — Signature — Requesting Provider
Enter the signature of the provider requesting this amendment.

Element 12 — Date Signed
Enter the month, day, and year this amendment was signed (in MM/DD/YYYY format).

Appendix 5

Prior Authorization Amendment Request (for photocopying)

(A copy of the Prior Authorization Amendment Request is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11042 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION AMENDMENT REQUEST

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 Amendment Request Completion Instructions (HCF 11042A).

SECTION I — RECIPIENT INFORMATION

1. Today's Date	2. Previous Prior Authorization Number
3. Name — Recipient (Last, First, Middle Initial)	4. Recipient Medicaid Identification No.

SECTION II — PROVIDER INFORMATION

5. Name — Billing Provider	6. Billing Provider's Medicaid Provider No.
7. Address — Billing Provider (Street, City, State, ZIP Code)	8. Amendment Effective Dates

SECTION III — AMENDMENT INFORMATION

9. List reasons for Amendment Request

10. Indicate procedure(s) to be amended by hours per day and days per week, multiplied by the number of weeks.

Registered Nurse _____

Licensed Practical Nurse _____

Home Health Aide _____

Physical Therapist _____

Occupational Therapist _____

Speech-Language Pathologist _____

Personal Care Worker _____

Other _____

11. **SIGNATURE** — Requesting Provider	12. Date Signed

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