

Hearing Services

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Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's ID card or EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare Hearing Services Handbook is issued to audiologists and hearing instrument specialists who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

Handbook Organization

The Hearing Services Handbook consists of the following chapters:

- General Information.
- Covered Hearing Instrument Specialist Services and Related Limitations.
- Covered Audiologist Services.
- Covered Hearing Instruments and Related Limitations.
- Prior Authorization Requirements and Submission.
- Claims Submission.

In addition to the Hearing Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

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 430-456 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.497 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses,

and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

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General Information

This chapter outlines general information that applies to both hearing instrument specialists and audiologists.

For the purposes of this handbook, the services that are provided by both hearing instrument specialists and audiologists are referred to as “hearing services.”

For the purposes of this handbook, the services that are provided by both hearing instrument specialists and audiologists are referred to as “hearing services.” Specific services that can only be provided by one provider type are noted.

This chapter also provides information for recipient enrolled in Medicaid managed care programs. For general recipient information, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Provider Certification Information

For general information on provider certification, refer to the Provider Certification section of the All-Provider Handbook.

Hearing Instrument Specialists

Hearing instrument specialists licensed pursuant to s. 459.05, Wis. Stats., may become Wisconsin Medicaid certified, as stated in HFS 105.41, Wis. Admin. Code.

Wisconsin Medicaid assigns each hearing instrument specialist a performing provider number that may be used for requesting prior authorization (PA) and submitting claims.

Audiologists

Audiologists may be certified by Wisconsin Medicaid if they meet one of the following requirements in HFS 105.31, Wis. Admin. Code:

- Have completed the educational requirements and be in the process of accumulating the work experience

required to qualify for the certificate of clinical competence.

- Have completed the educational requirements* and work experience† necessary for such ASHA certification.
- Possess a current certification of clinical competence from the American Speech and Hearing Association (ASHA), currently referred to as the American Speech Language Hearing Association.

*Educational requirements consist of both:

- A Master’s or Doctoral degree in audiology.
- Successful completion of the national examination in the area for which the ASHA certificate is sought.

†Work experience consists of successful completion of a clinical fellowship.

Wisconsin Medicaid assigns each audiologist a performing provider number that may be used for requesting PA or submitting claims.

Section 459.24, Wis. Stats., requires that all persons engaging in the practice of audiology or using the title of audiologist, clinical audiologist, or any similar title must be licensed as an audiologist with the Department of Regulation and Licensing, Hearing and Speech Examining Board. No information on Wisconsin Medicaid certification or provision of services may be construed to supersede the provisions for registration or licensure under 1989 Wisconsin Act 316.

For information on registration and licensure, contact:

Wisconsin Department of Regulation and Licensing
Hearing and Speech Examining Board
PO Box 8935
Madison WI 53708

Speech and Hearing Clinics

Speech-language and hearing clinics accredited by the ASHA pursuant to the ASHA-published guidelines for “accreditation of professional services programs in speech pathology and audiology” may become Wisconsin Medicaid certified, as stated in HFS 105.29, Wis. Admin. Code.

Each hearing instrument specialist and audiologist employed by a speech-language and hearing clinic is required to be individually certified by Wisconsin Medicaid and have an individual performing provider number.

Wisconsin Medicaid assigns each speech-language and hearing clinic a group billing number that requires a separate performing provider number for requesting PA and submitting claims.

Provider Records

According to HFS 106.02(9), Wis. Admin. Code, all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records.

The recipient’s permanent record must include the following, as appropriate:

- A dated, written report of the evaluation results with the applicable test chart or test form.
- A written entry for each date a hearing service is provided to the recipient.
- The dated, signed physician’s prescription for the required hearing services and/or devices, as appropriate.
- The recipient’s plan of care, if applicable, signed and dated by the prescribing physician.

Note: Refer to the Covered Audiologist Services and Related Limitations chapter of this handbook for more information on the plan of care requirements.

In the event of a provider audit, auditors will review any or all of the provider/recipient records, as maintained per HFS 105.02, 106.02(9), and 107.02(2)(e), Wis. Admin. Code, that support reimbursement for a specific date of service (DOS). Wisconsin Medicaid considers records limited to checklists with attendance, procedure codes, and units of time as insufficient to meet this DOS documentation.

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for information on safeguarding recipient information and maintaining recipient records.

Prescription

As specified in HFS 107.02(2m) and 107.19, Wis. Admin. Code, Wisconsin Medicaid will only cover hearing services that are prescribed by a physician. In addition, all hearing instruments require a physician prescription, as stated in HFS 107.24(2)(a), Wis. Admin. Code, except for the following as noted in HFS 107.02(2m), Wis. Admin. Code:

- Accessories that are not part of an initial purchase.
- Hearing aid batteries.
- Repairs.

The prescription must be in writing and kept in the recipient’s permanent record.

Evaluations

Providers are required to include a written report of the evaluation results with the applicable test chart or test form in the recipient’s medical record. The evaluation must be consistent with licensure and standards of practice to confirm fitting of the monaural or binaural hearing instrument.

As specified in HFS 107.02(2m) and 107.19, Wis. Admin. Code, Wisconsin Medicaid will only cover hearing services that are prescribed by a physician.

Daily Entry

Hearing services providers are required to write a note in the recipient's record for every DOS. The entry must include the following:

- Date of service.
- Duration of the treatment session. Good standards of recordkeeping include documenting the start and end times for each treatment session.
- Objective measurement of the recipient's response during the treatment session.
- Problem(s) treated.
- Signature and credentials of the performing provider and, when the service is provided by a student, the signature and credentials of the appropriate supervising therapist.
- Specific treatment activities/interventions as well as the associated procedure codes.

Wisconsin Medicaid strongly recommends that providers verify the recipient's current enrollment in a Wisconsin Medicaid managed care program before providing services.

HealthCheck "Other Services"

For Medicaid recipients less than 21 years of age, medically necessary services that are not otherwise covered by Wisconsin Medicaid or that exceed Medicaid limitations may be covered for those who meet age requirements under the HealthCheck "Other Services" program when prior authorized. (HealthCheck is Wisconsin Medicaid's name for the federally mandated childhood preventive health program known as Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]. HealthCheck is available only to Wisconsin Medicaid recipients who are less than 21 years of age.)

Wisconsin Medicaid covers medically necessary hearing services. A denied PA request for hearing services generally is not approved under the HealthCheck "Other Services" benefit.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for additional information on HealthCheck "Other Services."

Noncovered Services

Wisconsin Medicaid does not reimburse for the following:

- As specified under HFS 107.19(4)(a), Wis. Admin. Code, activities such as end-of-the-day clean-up time, transportation time, consultations, and required paper reports. These are considered components of the provider's overhead costs and are not separately reimbursable.
- As specified under HFS 107.19(4)(b), Wis. Admin. Code, services provided by individuals who are not certified under HFS 105.31 or HFS 105.41, Wis. Admin. Code.
- As specified in HFS 101.03(96m) and HFS 107.035, Wis. Admin. Code, services determined by Wisconsin Medicaid as not medically necessary and/or experimental.
- Services described as noncovered services in the Covered and Noncovered Services section of the All-Provider Handbook.

Recipient Information

Before delivering services, Wisconsin Medicaid providers should always verify a recipient's eligibility to discover any limitations to the recipient's coverage, and to determine if the recipient is enrolled in a Wisconsin Medicaid managed care program. The Wisconsin Medicaid Eligibility Verification System (EVS) provides eligibility information that providers may access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for more information on the EVS.

Recipients Enrolled in Medicaid Managed Care Programs

Wisconsin Medicaid strongly recommends that providers verify the recipient's current enrollment in a Wisconsin Medicaid managed care program before providing services. Wisconsin Medicaid denies claims submitted for services covered by Medicaid managed care programs when the services are provided

to recipients enrolled in Wisconsin Medicaid managed care programs. If a recipient is enrolled in a Wisconsin Medicaid managed care program, providers should submit claims to that managed care program.

For recipients enrolled in a Medicaid managed care program, all conditions of reimbursement and PA for hearing services are established by the contract between the managed care program and its affiliated providers.

Hearing services provided in the school are not covered through Medicaid managed care programs. Refer to the Managed Care Guide for more information on Medicaid managed care programs.

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Covered Hearing Instrument Specialist Services and Related Limitations

For information on covered hearing services equipment and related limitations, refer to the Covered Hearing Instruments and Related Limitations chapter of this handbook.

This chapter outlines covered hearing instrument specialist services and related limitations for hearing services. For information on covered hearing services equipment and related limitations, refer to the Covered Hearing Instruments and Related Limitations chapter of this handbook.

Audiologists may provide all the services identified in this chapter. For additional services that audiologists may provide, refer to the Covered Audiologist Services chapter of this handbook.

As specified in HFS 107.02(2m) and 107.19, Wis. Admin. Code, all hearing services require a written prescription, which must be maintained in the recipient's record. Wisconsin Medicaid only covers medically necessary services. Many hearing services also require prior authorization (PA) to receive reimbursement from Wisconsin Medicaid. Refer to the Prior Authorization chapter of this handbook for more information on requesting PA.

Covered Hearing Instrument Specialist Services

Hearing instrument specialists may provide services that are defined as Healthcare Common Procedure Coding System (HCPCS) codes. Wisconsin Medicaid-allowable HCPCS codes are included in Appendix 2 of this handbook. Wisconsin Medicaid will not cover *Current Procedural Terminology* (CPT) codes (Appendix 1 of this handbook) when

these services are provided by hearing instrument specialists. Refer to the Claims Submission chapter of this handbook for more information on HCPCS and CPT codes.

Audiologists may provide services to all Medicaid recipients regardless of age, impairment, or special needs.

As stated in HFS 107.24(3)(h)1, Wis. Admin. Code, hearing instrument specialists may only provide services to recipients who:

- Are *not* cognitively or behaviorally impaired.
- Are over 21 years of age.
- Have no special or medical needs which would necessitate either the diagnostic tools of an audiologist or a comprehensive evaluation requiring the expertise of an audiologist. (Refer to "Special Needs" in the Prior Authorization chapter of this handbook for an explanation of special needs.)

Hearing instrument specialists may fit hearing instruments for those who do not fall in the above categories.

Refer to the Covered Audiologist Services chapter in this handbook for more information.

Hearing Aid Dispensing

Wisconsin Medicaid covers hearing aid dispensing and fitting when the service is provided by a Wisconsin Medicaid-certified hearing instrument specialist. The dispensing fee includes the following services:

- A one-year service guarantee and any necessary service to maintain proper function of the hearing aid.
- Ear mold impression.
- Initial office visit.
- Proper fitting of the hearing aid.
- Up to five post-fittings as necessary for adjustments and hearing aid orientation. (This includes performance checks.)

Covered, Nonreimbursable Services

A hearing instrument specialist may measure hearing solely for the purpose of making selections, adaptations, or sales of hearing aids and perform hearing aid evaluations consistent with licensure and standards of practice, to be included in a PA report, if these evaluations are prescribed by a physician and in accordance with HFS 107.24(3)(h)a, Wis. Admin. Code. The evaluation is considered part of the overhead cost and is not separately reimbursable.

Wisconsin Medicaid covers hearing aid dispensing and fitting when the service is provided by a Wisconsin Medicaid-certified hearing instrument specialist.

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Covered Audiologist Services

As specified in HFS 107.02(2m) and HFS 107.19, Wis. Admin. Code, all hearing services require a prescription, which must be maintained in the recipient's medical record. Wisconsin Medicaid only covers medically necessary services.

This chapter outlines covered audiologist services for hearing services. For information on covered hearing equipment and related limitations, refer to the Covered Hearing Instruments and Related Limitations chapter of this handbook.

Wisconsin Medicaid only covers the services outlined in this chapter when they are provided by audiologists. In addition, audiologists may provide all the services outlined in the Covered Hearing Instrument Specialist Services and Related Limitations and Covered Hearing Instruments and Related Limitations chapters of this handbook.

As specified in HFS 107.02(2m) and HFS 107.19, Wis. Admin. Code, all hearing services require a prescription, which must be maintained in the recipient's medical record. Wisconsin Medicaid only covers medically necessary services. Many hearing services also require prior authorization (PA) to receive reimbursement from Wisconsin Medicaid. Refer to the Prior Authorization chapter of this handbook for more information on requesting PA.

Covered Audiology Services

As stated in HFS 107.19, Wis. Admin. Code, covered audiology services are those medically necessary screening, diagnostic, preventive, or corrective audiology services prescribed by a physician and provided by an audiologist.

Covered services include:

- Audiological evaluations, including:
 - √ Hearing aid or other assistive listening device (ALD) evaluations.
 - √ Pure tone air and bone conduction.
 - √ Speech thresholds and word recognition.
- Audiological tests. Other audiological tests may be used in conjunction with any evaluation technique when indicated.
- Audiometric techniques. Special audiometric techniques are defined as modifications of standard tests to suit the needs of recipients who are physically or developmentally disabled who cannot respond to standard or conventional audiologic techniques.
- Aural rehabilitation. Aural rehabilitation is defined as therapy services provided to a hearing impaired or deaf client in individual or group sessions, which generally fall into the following categories:
 - √ Auditory training. The systematic use of residual hearing potential to improve communication of persons with impaired hearing, with or without amplification.
 - √ Nonverbal communications. The process of assisting patients to communicate through the use of non-verbal language such as Bliss symbols, signing, and finger spelling.
 - √ Speech/lip reading. The process through which an individual, regardless of the state of his or her hearing, understands speech by carefully watching the speaker.
- Hearing aid or other ALD performance check.
- Impedance audiometry. [Acoustic immittance tests.]
- The following speech and language pathology services:
 - √ Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status.
 - √ Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual.

- √ Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals.

Audiologists may provide hearing services to all eligible Wisconsin Medicaid recipients. As required by HFS 107.24(3)(h)1, Wis. Admin. Code, evaluation and testing for hearing instruments and modifications may only be performed by an *audiologist* for recipients who:

- Are cognitively or behaviorally impaired.
- Are 21 years of age or younger.
- Have special needs that would necessitate either the diagnostic tools of an audiologist or a comprehensive evaluation requiring the expertise of an audiologist.

Procedure Codes for Covered Services

Audiologists may provide services that are defined by both Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology* (CPT) codes. HCPCS codes are listed in Appendix 2 of this handbook. *Current Procedural Terminology* codes are listed in Appendix 1 of this handbook. Refer to the Claims Submission chapter of this handbook for more information on CPT and HCPCS codes.

Plan of Care

As stated in HFS 107.19(3)(a), Wis. Admin. Code, audiology providers are required to establish a *written* plan of care for all recipients prior to the provision of audiology services. The plan of care must include the physician's signature and must be maintained in the recipient's record.

The plan of care should be reviewed by the attending physician in consultation with the audiologist providing the active treatment or care at least every 90 days, per HFS 107.19(3)(a)2, Wis. Admin. Code.

As stated in HFS 107.19(3)(a), Wis. Admin. Code, audiology providers are required to establish a *written* plan of care for all recipients prior to the provision of audiology services.

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Covered Hearing Instruments and Related Limitations

Both audiologists and hearing instrument specialists may dispense hearing instruments.

This chapter examines covered hearing instruments and related limitations.

Hearing instruments consist of:

- Assistive listening devices (ALDs).
- Hearing aids.
- Hearing aid accessories.

Both audiologists and hearing instrument specialists may dispense hearing instruments. As required by HFS 107.24(3)(h)1, Wis. Admin. Code, evaluation and testing for hearing instruments and modifications may only be performed by an *audiologist* for recipients who:

- Are cognitively or behaviorally impaired.
- Are 21 years of age or younger.
- Have special needs that would necessitate either the diagnostic tools of an audiologist or a comprehensive evaluation requiring the expertise of an audiologist.

As specified in HFS 107.02(2m), Wis. Admin. Code, all hearing instruments require a prescription, except for:

- Accessories that are not part of an initial purchase.
- Hearing aid batteries.
- Repairs.

The physician's written prescription must be maintained in the recipient's medical record. The prescription is good for one year.

Wisconsin Medicaid only covers medically necessary hearing instruments. Prior authorization (PA) is required prior to dispensing most hearing instruments. Refer to the Prior Authorization Requirements and Submission chapter of this handbook for more information on PA.

Refer to Appendix 3 of this handbook for a quick-glance table that details the life expectancy, limitations, and PA requirements for hearing instrument packages and services.

Freedom of Choice of Providers

After they have obtained a prescription, Wisconsin Medicaid allows fee-for-service recipients to select the certified hearing services provider of their choice to dispense a hearing instrument.

Upon approval of a PA request for a hearing instrument, Wisconsin Medicaid sends the recipient:

- A copy of the PA request that the recipient presents to the certified provider of his or her choice.
- A letter informing the recipient of his or her ability to choose a hearing instrument provider. (Refer to Appendix 5 of this handbook for a copy of the letter.)

Note: The PA request does not guarantee recipient eligibility on the date of service. Providers are strongly advised to check recipient eligibility prior to providing a service.

Hearing Aids

Wisconsin Medicaid covers the following types of monaural or binaural hearing aids:

- Analog or conventional hearing aids.
- Digital hearing aids.
- Digitally programmable hearing aids.
- Modifications of any of the above hearing aids when a recipient exhibits a special need for such an adaptation.

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The initial monaural hearing aid purchase includes an ear mold, cord, and one package of batteries. The initial binaural hearing aid purchase includes two ear molds, two cords, and two packages of batteries.

Eligible Wisconsin Medicaid recipients are limited to one hearing aid per ear every three years.

Hearing Aid Accessories

Wisconsin Medicaid covers the following hearing aid accessories separate from the initial package:

- Bone conduction receivers with headband.
- Direct audio input shoes.
- Harness. Hearing aid harnesses or other supporting devices.
- New receiver. Hearing aid receivers for body-worn hearing aids.

Limitations

The limitations on hearing aid accessories are as follows, per HFS 107.24(4)(g), Wis. Admin. Code:

- All recipients: one harness, one CROS fitting, one new receiver per hearing aid, and one bone conduction receiver with headband per recipient per year.
- Recipients age 18 and younger: three ear molds per hearing aid, two single cords per hearing aid, and two Y-cords per recipient per year.
- Recipients over age 18: one ear mold per hearing aid, one single cord per hearing aid, and one Y-cord per recipient per year.

Assistive Listening Devices

Wisconsin Medicaid only covers ALDs that meet the following criteria:

- The ALD has a standard amplifier.
- The ALD has one or two receivers (monaural or binaural earphones) with single or Y-cord.

- The system is battery operated (disposable battery).
- The system is portable.

Wisconsin Medicaid reimbursement for ALDs includes the necessary batteries and ear molds. Wisconsin Medicaid does not separately reimburse for the batteries and ear molds.

Eligible Wisconsin Medicaid recipients are limited to one ALD every three years.

Performance Checks

As noted in HFS 107.24(3)(h)2, Wis. Admin. Code, performance checks are required for new hearing aids and ALDs.

Audiologists submit a claim for all procedures included in dispensing the hearing instrument after the performance check has been completed. Refer to the Prior Authorization chapter of this handbook for more information.

Hearing Aid Batteries

Wisconsin Medicaid covers hearing aid batteries when they are provided in accordance with specific claims submission instructions and limitations.

The maximum quantity allowed per recipient per calendar month is 12 batteries, regardless of whether the request is for one type of battery or a combination of different batteries.

Hearing aid batteries are not included in the nursing home or home care daily rates and may be separately reimbursed by Wisconsin Medicaid. Refer to the Disposable Medical Supplies Handbook (available on the Medicaid Web site at www.dhfs.state.wi.us/medicaid/) for more information on separate reimbursement for disposable medical supplies.

Prior authorization is required to request batteries beyond the monthly 12-battery threshold or if no procedure code for the battery type exists.

Hearing aid batteries are not included in the nursing home or home care daily rates and may be separately reimbursed by Wisconsin Medicaid.

Refer to Appendix 2 of this handbook for hearing aid battery procedure codes.

Repairs

Repairs are allowed once every six months without PA for purchased hearing instruments. Prior authorization is required if a second repair is needed within six months of a previous repair.

Limitations

Wisconsin Medicaid will not reimburse for:

- Major and minor repairs on items that are covered under warranty (usually within one year of dispensing).
- Major and minor repairs on the same DOS for the same hearing instrument.
- Repairs on rented hearing instruments.

Hearing Aid Recasing

Recasing or replacement of a hearing aid case is covered at a frequency of once per six-month period.

Recasing is noncovered if:

- The hearing aids are subject to maltreatment, misuse, tampering, or unauthorized repair.
- The recasing is to change the case or covering color.

Hearing Instrument Modifiers

Providers must use the following modifiers with procedure codes for hearing instruments and related services:

- LT — Left ear.
- RT — Right ear.
- 52 — Minor repairs.
- 22 — Recasing or replating.
- RR — Rental. For rented hearing instruments, providers are required to always use modifier “RR” when type of service “R” is used.

- 50 — Both ears. For repairs, ear molds, supplies, and accessories. Do not use modifier “50” for purchases or rentals of hearing aid packages. Procedure codes for purchases and rentals already indicate if the instrument is binaural or bilateral.

When a provider dispenses two hearing instruments on the same DOS for the same recipient, providers must bill using a binaural or bilateral procedure code.

Noncovered Hearing Instruments and Related Services

In accordance with HFS 107.24(5), Wis. Admin. Code, Wisconsin Medicaid does not reimburse for:

- Earplugs for hearing protection.
- Hearing aid or ALD repairs (major or minor) performed within the 12 months after purchase.
- Items which are for comfort and convenience, or luxury features which do not contribute to the improvement of the recipient’s medical condition.
- Items which are not generally accepted by the medical profession as being therapeutically effective.
- Items which are not primarily medical in nature.
- Repairs on rented hearing aids or ALDs.

Additional Noncovered Services

As explained in HFS 107.24(3)(h)1, Wis. Admin. Code, Wisconsin Medicaid will not reimburse for evaluation and testing for hearing instruments and modifications provided by a hearing instrument specialist.

When a provider dispenses two hearing instruments on the same DOS for the same recipient, providers must bill using a binaural or bilateral procedure code.

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Prior Authorization Requirements and Submission

Providers need PA for specified services/items *before* delivery, unless the service is an emergency.

According to HFS 107.02(3)(b), Wis. Admin. Code, prior authorization (PA) procedures are designed to:

- Assess the quality and timeliness of services.
- Determine if less-expensive alternative care, services, or supplies are usable.
- Promote the most effective and appropriate use of available services and facilities.
- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payment.

Providers need PA for specified services/items *before* delivery, unless the service is an emergency. Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved PA form. If the provider delivers a service that requires PA without obtaining PA, the *provider* is responsible for the cost of the service.

Prior authorization does not guarantee payment. Provider and recipient eligibility on the date of service, as well as all other Medicaid requirements, must be met before the claim is paid.

Refer to the Prior Authorization section of the All-Provider Handbook for information on the following PA situations:

- Amending approved or modified PA requests.
- Appeal procedures.
- Emergency situations.
- HealthCheck “Other Services.”

- Prior authorization for out-of-state providers.
- Recipient loss of eligibility midway through treatment.
- Retroactive authorization.
- Supporting documentation.
- Transferring authorization.

When Wisconsin Medicaid Requires Prior Authorization

The following services require PA:

- Aural rehabilitation:
 - ✓ Use of residual hearing.
 - ✓ Speech reading or lip reading.
 - ✓ Compensation techniques.
 - ✓ Gestural communication techniques.
- Dispensing of all hearing instruments.
- Purchase of any special modifications to hearing instruments.
- Purchase or rental of all hearing instruments.
- Replacement of any hearing instruments.
- Speech and language pathology (SLP) services. As stated in HFS 107.18, Wis. Admin. Code, SLP services provided by audiologists beyond the first 35 treatment days per spell of illness requires PA. In addition, SLP services require PA requests specifically for spell of illness, Birth to 3, and therapy services.
- Unlisted otorhinolaryngological service or procedure.

Recipient’s Special Needs

Wisconsin Medicaid considers a recipient’s special educational, social, vocational, and other needs when adjudicating PA requests for hearing instruments. The audiologist is required

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to document a recipient's special needs in the PA request or in an attachment to the PA request. Examples of special needs include:

- Educational.
 - √ Allowing effective education for an adult or child who is mentally or physically impaired.
 - √ Allowing effective education of a child who is under the age of 21.
- Social.
 - √ Enhancing a mentally or physically impaired recipient's social communication skills and abilities.
 - √ Enhancing a mentally or physically impaired recipient's capability for sound awareness (localization), e.g., for parenting, warning.
 - √ Expanding a recipient's social interaction or communication limited by additional disabilities, such as blindness.
- Vocational.
 - √ Improving a mentally or physically impaired recipient's ability to obtain employment or continue employment.

Special Circumstances

Unlisted Audiology Procedure Code 92599

Providers are to use *Current Procedural Terminology* (CPT) code 92599 (unlisted otorhinolaryngological service or procedure) for services or procedures for which there is *no specific* CPT procedure code.

Procedure code 92599 should be used only when there is no other code that describes the service or procedure being offered. Only audiologists may request PA or submit claims for this code; PA requests and claims submitted by hearing instrument specialists will be denied.

Prior authorization is always required when using this code.

Monaural or Binaural Hearing Instruments

Wisconsin Medicaid requires the following information on the PA request for monaural or binaural hearing instruments:

- Complete description of the hearing device, including style, electroacoustic specifications, and any modifications and adaptations.
- Complete documentation that supports the medical necessity of the request, including the diagnosis, appropriate audiological evaluation, and a description and diagnosis of any cognitive or behavioral impairments or other special needs.
- Documentation that the medically necessary hearing tests and evaluations have been performed to confirm fitting of the monaural or binaural hearing instrument.
- Recipient's primary and secondary diagnosis codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification* that relate to a hearing problem or developmental, cognitive, or neurological condition.

Additional Prior Authorization Requirements for Binaural Hearing Instruments

In addition to the general PA requirements described under "Monaural or Binaural Hearing Instruments" in this chapter, providers requesting a binaural hearing instrument are required to document that:

- Hearing tests and evaluations indicate that a binaural fitting will provide measurable, significant improvement in functional hearing compared to a monaural hearing instrument.
- The recipient has another sensory, cognitive, and/or developmental deficit that adds to the hearing problem, or other special need justifying binaural hearing aids for sound localization, central auditory processing, or word recognition in noise.

Providers are to use *Current Procedural Terminology* (CPT) code 92599 (unlisted otorhinolaryngological service or procedure) for services or procedures for which there is *no specific* CPT procedure code.

Prior authorization for the purchase of a hearing instrument, ALD, or modification is valid for six months from the date of approval.

Fitting and Dispensing Hearing Aids

Prior authorization is required for fitting and dispensing hearing aids.

Prior authorization for the purchase of a hearing instrument, ALD, or modification is valid for six months from the date of approval. Wisconsin Medicaid reimburses for one hearing aid per ear or one ALD every three years, unless unusual circumstances documented in the PA request demonstrates the need for exceeding the frequency limitation.

Providers should indicate Healthcare Common Procedure Coding System, formerly known as Healthcare Common Procedure Coding System, (HCPCS) codes on the PA request when seeking PA for fitting and dispensing of hearing instruments.

Hearing Instrument Modifications

Wisconsin Medicaid covers medically necessary modifications to hearing instruments with an approved PA request. Providers should use HCPCS code V5014 when requesting PA for modifications to hearing instruments. Procedure code V5014 must be used with modifier RT (right ear), LT (left ear), or 50 (both ears).

Examples of modifications and adaptations to a hearing instrument include:

- Compression amplification.
- Direct audio input.
- Power amplifiers.
- Silicone ear molds.
- Special canal-sized shells to accommodate ear canal fittings.
- Telephone coils.

In addition to the general PA requirements, providers submitting a PA request for hearing instrument modifications are required to:

- Clearly describe the modification requested.

- Document the medical necessity of the modification to restore or assist the recipient’s communicative capabilities and any special needs in social, educational, or vocational situations.

Second Major Hearing Aid Repair

Prior authorization is required to perform a second major repair of a hearing aid within 365 days of an original repair.

When requesting PA for a second major hearing aid repair, providers are required to submit the Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) form and the Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2) form.

Indicate the appropriate repair procedure code (V5014) on the PA request.

Completion of the Prior Authorization Physician Otological Report (PA/POR) is not required.

Required Documentation for Replacement of Hearing Instruments

A replacement hearing instrument may be approved within three years of initial purchase with PA. When replacement of a hearing instrument is requested, the following documentation is required:

- Evidence that it is more cost effective to replace the hearing instrument rather than continuing to repair it; or, evidence that the first hearing instrument did not meet the needs of the recipient.
- Prior Authorization Physician Otological Report (PA/POR)*.
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1).
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2).
- Recipient instruction on care and maintenance.

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PA Requirements and Submission

* Hearing instrument specialists are required to use the PA/POR for all PA requests for hearing instruments and supplies. However, audiologists are *not* required to use the PA/POR, but must maintain a record of medical clearance for the hearing instrument in the recipient's file.

Required Documentation When Requesting Replacement Hearing Instruments Due to Loss

A PA request for replacement of a lost or destroyed hearing instrument may be submitted at any time. The following documentation is required:

- A statement from the recipient or caregiver regarding the circumstances of the loss.
- Evidence of effort to find the hearing instrument.
- If applicable, a statement from the recipient or caregiver that insurance (e.g., home owners, property) does not cover replacement of the hearing instrument.
- Prior Authorization Physician Otolological Report (PA/POR)*.
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1).
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2).
- Provider statement that the hearing aid is not covered by a manufacturer's loss and damage warranty. If the warranty status of a lost or destroyed hearing instrument cannot be determined due to the involvement of more than one provider, a statement to that effect should be submitted.
- Recipient instruction on care and maintenance.

* Hearing instrument specialists are required to use the PA/POR for all PA requests for hearing instruments and supplies. However, audiologists are *not* required to use the PA/POR, but must maintain a record of

medical clearance for the hearing instrument in the recipient's file.

Procedure Code V5299

Use of procedure code V5299 — hearing service, miscellaneous — is limited to those instances when there is no other code to describe a specific hearing instrument or supply. Prior authorization is still required when using procedure code V5299.

Providers must include the following documentation when submitting PA requests for procedure code V5299:

- A complete description of the hearing instrument, including style, electroacoustic specifications, accessories, and the ear(s) to be fitted.
- Comments addressing why the specialized hearing instrument requested with procedure code V5299 will provide measurable, significant improvement in functional hearing compared to a standard hearing instrument, a digitally programmable analog hearing instrument, or a digital hearing instrument.
- Documentation verifying the cost, including a copy of manufacturer's information giving the list price.
- Prior Authorization Physician Otolological Report (PA/POR)* is required for all PA requests by Hearing Instrument Specialists.
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1).
- Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2).

* Hearing instrument specialists are required to use the PA/POR for all PA requests for hearing instruments and supplies. However, audiologists are *not* required to use the PA/POR, but must maintain a record of medical clearance for the hearing instrument in the recipient's file.

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Use of procedure code V5299 — hearing service, miscellaneous — is limited to those instances when there is no other code to describe a specific hearing instrument or supply.

Performance Checks

According to HFS 107.24(3)(h)2, Wis. Admin. Code, performance checks are required on all new and rented hearing instruments after a 30-day trial period. Wisconsin Medicaid will *not* process claims for dispensing the hearing instruments until after the 30-day trial period has expired.

According to HFS 107.24(3)(h)2, Wis. Admin. Code, performance checks are required on all new and rented hearing instruments after a 30-day trial period.

It is the recipient's responsibility to obtain a performance check. After the 30-day trial period, the provider may submit an audiological report (performance check) to Wisconsin Medicaid. The purpose of the report is to verify the appropriate fitting, performance, and medical necessity of the device.

Wisconsin Medicaid reviews the audiological report to ensure the hearing instrument is satisfactory before approving reimbursement.

Claims submitted for a hearing aid performance check should indicate the results of the check — whether positive or negative.

Providers are not required to submit an audiological report if 45 days or more have elapsed since the hearing instrument was dispensed.

HealthCheck "Other Services"

Medically necessary services which are not otherwise covered may be covered if they are provided to a recipient under age 21 as a result of a HealthCheck examination. All such services require PA.

To request PA for HealthCheck "Other Services," submit a Prior Authorization Request Form (PA/RF) and a PA/POR which clarifies the service to be provided and the medical necessity of the service. Indicate on the PA/RF that the request is for HealthCheck "Other Services." If the service is approved, Wisconsin Medicaid assigns a procedure code for the service. Always include a copy of the HealthCheck referral form indicating a referral

for the services with the PA request. The referral must have been made within the past 12 months. Additional information documenting the individual's need for the service and appropriateness of the service being delivered may be requested from the provider.

Required Prior Authorization Forms

Hearing Instrument Specialists

Hearing instrument specialists are required to submit the following forms when requesting PA for hearing services:

- A correctly completed PA/HIAS1.
- A correctly completed PA/HIAS2.
- A PA/POR (completed by a recipient's physician and submitted to Wisconsin Medicaid by the hearing instrument specialist).

Prior Authorization/Physician Otolological Report

Hearing instrument specialists are required to include the PA/POR form when submitting PA requests for hearing instruments. The recipient's referring physician is required to complete the PA/POR to assure the medical necessity of a hearing instrument. The PA/POR must:

- Describe the results of any special studies, such as caloric or postural tests.
- Document that the otological findings indicate the need for a hearing instrument.
- Provide a clinical diagnosis, medical condition, and brief medical history.
- State that the recipient is over 21 years of age and has no behavioral or cognitive impairments or special needs.

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Audiologists

Audiologists are required to submit the following forms when requesting PA for hearing services:

- A correctly completed PA/RF.
- A correctly completed Prior Authorization/Therapy Attachment (PA/TA).

When requesting PA for hearing instruments, audiologists are required to submit the following forms:

- A correctly completed PA/HIAS1.
- A correctly completed PA/HIAS2.

Speech and language pathology services require different PA request forms than for audiology services.

Sample Forms and Instructions

Refer to the following appendices of this handbook for instructions and completed samples of PA forms:

- Appendix 6 for PA/RF completion instructions.
- Appendix 7 for a sample PA/RF.
- Appendix 8 for PA/TA completion instructions.
- Appendix 9 for a blank PA/TA.
- Appendix 10 for PA/POR completion instructions.
- Appendix 11 for a sample PA/POR form.
- Appendix 12 for PA/HIAS1 completion instructions.
- Appendix 13 for a sample PA/HIAS1 form.
- Appendix 14 for PA/HIAS2 completion instructions.
- Appendix 15 for a sample PA/HIAS2 form.

Obtaining Prior Authorization Forms

Providers may obtain PA/RF, PA/TA, PA/POR, PA/HIAS1, and PA/HIAS2 forms by writing to:

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

Required Attachments

Audiologists are required to submit a copy of the written plan of care with the appropriate PA request form. If the required documentation is missing from the request form, Wisconsin Medicaid will return the request to the provider.

Submission of Prior Authorization Forms

To expedite the PA process, it is essential that providers follow the instructions found in this chapter and the Prior Authorization section of the All-Provider Handbook.

Contact Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883 with PA questions that are not answered in this chapter or in the Prior Authorization section of the All-Provider Handbook.

Providers have two choices for submitting completed PA requests:

- By fax.
- By mail.

Prior authorization requests received after 1 p.m. on business days are processed on the following business day. Prior authorization requests received on weekends or legal holidays are processed on the next business day.

Wisconsin Medicaid makes decisions on PA requests within the time frames outlined in the Prior Authorization section of the All-Provider Handbook, regardless of whether the requests are mailed or faxed.

Note: Providers are required to submit PA requests containing X-rays, video tapes, or photos by mail.

Audiologists are required to submit a copy of the written plan of care with the appropriate PA request form.

Submission by Fax

Providers may fax PA requests to Wisconsin Medicaid at (608) 221-8616.

When faxing PA requests, providers are required to submit all forms and documentation together; they should not fax the forms and then mail the supporting documentation separately.

Refer to Appendix 19 of this handbook for more procedures on faxing PA requests.

Response Back From Wisconsin Medicaid

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

- “We are unable to read your faxed PA request. Please resubmit the same request.”
- “Your request(s) has been adjudicated. See attached PA request(s) for the final decision.”
- “Your request(s) requires additional information. See attached PA request(s). Fax the requested information with the same PA form immediately to expedite the finalization of your request.”

When additional information is requested, providers are required to resubmit the faxed copy of the entire original PA request, including attachments, with the additional information requested. If any attachments or additional information are received without the rest of the PA request, the information will be returned to the provider.

Providers are required to resubmit the faxed copy because it includes Wisconsin Medicaid’s 15-digit internal control number on the top-half of the form. This allows the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility).

Wisconsin Medicaid will mail the decision back to the provider if:

- The fax is not successfully transmitted after three attempts.
- The provider does not include his or her fax number on the transmittal form.

Submission by Mail

Providers may mail completed PA requests to:

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

For reference or further correspondence, providers are encouraged to photocopy their paperwork before mailing it to Wisconsin Medicaid.

Response to Prior Authorization Requests

Providers may inquire about the status of a request by accessing the Automated Voice Response system or by contacting Provider Services at (800) 947-9627 or (608) 221-9883.

Wisconsin Medicaid recognizes that a recipient’s abilities, needs, and medical conditions are unique and have the potential to change. Therefore, approval of one PA does not guarantee approval of all PAs.

Conversely, a denied PA should not be interpreted to mean that services will not meet the definition of medical necessity in the future. Every PA request stands on its own merit, documenting the need for services and describing the recipient’s unique circumstances at that time.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on Wisconsin Medicaid responses to PA requests.

Providers may inquire about the status of a request by accessing the Automated Voice Response system or by contacting Provider Services at (800) 947-9627 or (608) 221-9883.

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Review of Prior Authorization Decisions

After review by Wisconsin Medicaid consultants, the PA request is:

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

Refer to the Prior Authorization section of the All-Provider Handbook for more information on each of these responses.

Only recipients can appeal modified or denied PA requests. When a request is modified or denied, the recipient receives a “Notice of Appeal Rights” letter. Refer to the Prior Authorization section of the All-Provider Handbook for a copy of this letter and for information on how a provider and a recipient may respond to Wisconsin Medicaid’s review of a PA request.

Amending Approved Prior Authorization Requests

When medically necessary, providers may request an amendment of approved or modified PA requests to change:

- The frequency of treatment.
- The grant or expiration dates.
- The specific treatment codes.

Prior authorization expiration dates may be amended up to one month beyond the original expiration date if the additional services are medically necessary.

The request to amend the PA/RF, PA/TA, PA/POR, PA/HIAS1, or PA/HIAS2 should include:

- A copy of the original request form.
- A corresponding physician’s prescription, if necessary.

- A document explaining or justifying the requested changes.
- The specific, requested changes to the request form.

The request to amend a PA form may be mailed to the PA Unit at:

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

Providers may also fax amendment requests to (608) 221-8616.

Amendment Request Approval Criteria

Wisconsin Medicaid may approve an amendment request if the request is:

- Fully explained and documented. Clinical documentation of the medical necessity justifying the request is required.
- Medically necessary under HFS 101.03 (96m), Wis. Admin. Code.
- Submitted before the date of the requested change.

Note: At the end of a possible extension period, providers are required to submit a new request for PA instead of requesting an extension if one of the following occurs:

- The recipient’s medical condition changes significantly, requiring a new plan of care.
- Similar services are expected to be medically necessary.

Reasons Prior Authorization Amendment Requests Are Denied

Wisconsin Medicaid may deny PA amendment requests for such reasons as:

- The PA expired prior to receipt of the amendment request.

Only recipients can appeal modified or denied PA requests.

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- The recipient's medical condition changes significantly, requiring a new plan of care.
- The requests are not medically necessary.
- The requests are not received before the date of the requested change.
- The requests are solely for the convenience of the recipient, the recipient's family, or the provider.
- The requests are to allow for a vacation, missed appointments, illness, or a leave of absence by either the recipient or the provider.
- Similar services are expected to be medically necessary following the expiration date of the approved PA amendment.

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Claims Submission

Claims Submission

All claims, whether electronic or paper, are subject to the same Wisconsin Medicaid processing and legal requirements.

Electronic Claims Submission

All providers are encouraged to submit claims electronically. Electronic claims submission:

- Eliminates manual handling of claims.
- Reduces both claims submission and processing errors.
- Reduces processing time.

Wisconsin Medicaid provides free software for electronic claims submission.

Providers who want to submit claims electronically are required to complete an Electronic Media Agreement Form. The form serves as the provider's signature. For more information on the Electronic Media Agreement Form, Wisconsin Medicaid's requirements for electronic claims submission, and general electronic claims submission information:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746 and ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claims Submission

Providers submitting paper claims are required to use the CMS 1500 claim form (dated 12/90). Refer to Appendix 16 of this section for CMS 1500 claim form completion instructions. Appendix 17 of this handbook contains an example of a completed CMS 1500 claim form

for hearing instrument specialist services. Appendix 18 of this handbook contains an example of a completed CMS 1500 claim form for audiologist services.

Wisconsin Medicaid denies claims for hearing services submitted on any paper claim form other than the CMS 1500 claim form.

Wisconsin Medicaid does not provide the CMS 1500 claim form. Providers may obtain these forms from any vendor who sells federal forms.

Where to Send Your Claims

Mail completed CMS 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claims submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook.

Coordination of Benefits

Generally, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other insurance (including Medicare), Wisconsin Medicaid reimburses that portion of the

All providers are encouraged to submit claims electronically.

Medicaid allowable cost remaining after all other insurance sources have been exhausted. Refer to the Coordination of Benefits section of the All-Provider Handbook for more detailed information on submitting claims to commercial health insurance and Medicare.

Medicare/Medicaid Dual Entitlement

Medicare may reimburse for hearing services under Part B coverage. *Medicare*-certified providers are required to bill Medicare prior to billing Wisconsin Medicaid for all hearing services provided to dual entitlements or Qualified Medicare Beneficiary-Only recipients.

Medicare Crossover Claims for Services

A Medicare crossover claim is a Medicare-allowed claim for a dual entitlement that is sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

Wisconsin Medicaid reimburses providers for the amount of Medicare's deductible for Medicare crossover claims. Payments for Medicare coinsurance on certain service crossover claims from Medicare are limited to Medicaid maximum allowable fees or the Medicare coinsurance amount, whichever is less. Wisconsin Medicaid will not reimburse providers for services denied by Medicare for policy reasons other than lack of medical necessity, or for billing errors. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information.

Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary-Only recipients are eligible only for Wisconsin Medicaid payment of coinsurance and deductible on crossover claims.

Billed Amounts

Billed Amounts for Hearing Services

Providers are required to bill their usual and customary charge for the hearing service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Wisconsin Medicaid a higher fee for the same service than that charged to a private-pay patient.

Billed Amounts for Hearing Instruments

Under the provider terms of reimbursement, providers are required to submit claims for their "net cash outlay cost" for hearing instrument packages. The "net cash outlay cost" is defined as the invoice cost including end-of-month discounts; i.e., the actual cost to the provider to permit the provider to fully recover his or her out-of-pocket cost for the purchase of the hearing instrument package furnished to the Wisconsin Medicaid recipient.

End-of month volume discounts are to be considered for the purpose of computing the purchaser's net cash outlay cost.

Reimbursement

Obtaining Maximum Allowable Fee Schedules

Separate maximum allowable fee schedules exist for hearing services and hearing instruments. To obtain a fee schedule or to

Separate maximum allowable fee schedules exist for hearing services and hearing instruments.

The initial hearing aid purchase, including one ear mold, one cord, and one package of batteries, is paid at the lesser of the maximum allowable fee or the provider's net cash outlay cost.

ensure you have the most recent fee schedule, you may:

- Download an electronic version from the Wisconsin Medicaid Web site at www.dhfs.state.wi.us/medicaid/.
- Purchase a paper schedule by calling Provider Services at (800) 947-9627 or (608) 221-9883, or by writing to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Providers may contact Provider Services for the cost of the fee schedule.

Reimbursement for Hearing Services

Providers are reimbursed at the lesser of their billed amount (net cash outlay) or the maximum allowable fee for hearing services. Providers are reminded that they cannot seek payment from recipients for any difference between their billed amounts and the Medicaid maximum allowable fee.

The maximum allowable fee is the maximum amount Wisconsin Medicaid will pay a provider for an allowable procedure code. For hearing services, the maximum allowable fee applies to one treatment unit that coincides with the specific *Current Procedural Terminology* (CPT) procedure code. Payment for treatment less than the CPT procedure code unit per session is prorated.

Wisconsin Medicaid maximum allowable fees for CPT codes for audiology services are based on the national standard Medicare Relative Value Units (RVUs). These fees apply to all providers, including audiologists, submitting claims for these procedure codes. The resource-based relative value scale assigns the RVU based on the complexity of procedures. The provider's work (physical and mental intensity, time taken to perform the service, non-face-to-face work) for each procedure, practice expenses, and liability

insurance are considered when determining the RVU.

Relative Value Units are based on the expectation that the code definition represents exactly how the service was provided when submitting the claim to Wisconsin Medicaid.

Initial Hearing Aid and Accessories

When submitting claims for the initial hearing aid purchase, providers are required to indicate the name of the referring prescribing physician or audiologist in Elements 17 and 17a of the CMS 1500 claim form.

The initial hearing aid purchase, including one ear mold, one cord, and one package of batteries, is paid at the lesser of the maximum allowable fee or the provider's net cash outlay cost. Payment for the purchase of a binaural hearing aid includes two ear molds and two packages of batteries. Accessories are not separately reimbursable items at the time of the initial purchase.

Note: Net cash outlay cost should not include any mailing charges, handling charges, etc.

Accessories

Wisconsin Medicaid reimburses for hearing aid accessories that are not a part of the initial hearing aid package. Wisconsin Medicaid reimburses accessories at the lesser of the provider's billed amount or the maximum allowable fee.

Claims for hearing instrument accessories, batteries, and repairs that are not part of the initial service do not require a referring/prescribing physician or audiologist.

Batteries

Hearing aid batteries that are not a part of the initial hearing aid package are reimbursed at the lesser of the billed amount or the maximum allowable fee. Refer to Appendix 2 of this handbook, or to the Disposable Medical Supplies (DMS) Index, for a list of hearing aid battery procedure codes.

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Claims Submission

Dispensing Fee

Wisconsin Medicaid reimburses for one dispensing fee with the purchase of a medically necessary hearing instrument when Wisconsin Medicaid has authorized the dispensing of the instrument. Wisconsin Medicaid reimburses the dispensing fee at the lesser of the provider's billed amount or the maximum allowable fee.

Reimbursement for the following services are included in the total dispensing fee:

- Initial office visit, ear mold impression, and fitting of the proper hearing aid.
- One-year service guarantee and any necessary service.
- Up to five post-fitting follow-up office visits as necessary for adjustments and hearing aid orientation.

After receiving the hearing aid, the recipient returns to the audiologist for a 30-day performance check. The audiologist attaches a report of the performance check (whether positive or negative) to the claim and submits the claim to Wisconsin Medicaid.

Providers are not required to submit an audiological report if 45 days or more have elapsed since the hearing instrument was dispensed.

Wisconsin Medicaid does not reimburse dispensing fees for hearing instrument rentals or assistive listening devices.

Repairs

Repairs are allowed once every six months without PA for purchased hearing instruments. Prior authorization is required if a second repair is needed within six months of a previous repair.

Major repairs

Claims for major hearing instrument repairs are submitted using procedure code V5014.

Major hearing instrument repairs are those that cannot be repaired in the provider's office and require sending the hearing instrument to the manufacturer. Major repairs do *not* require a "52" or "22" repair modifier.

Minor repairs

Minor repairs are those that can be performed in the provider's office. For minor repairs, providers should use procedure code V5014 with modifier "52."

Limitations

Wisconsin Medicaid will not reimburse for:

- Major and minor repairs on items that are covered under warranty (usually within one year of dispensing).
- Major and minor repairs on the same DOS for the same hearing instrument.
- Repairs on rented hearing instruments.

Hearing Aid Recasing

Recasing or replacement of a hearing aid case is covered at a frequency of once per six-month period.

Recasing is noncovered if:

- The hearing aids are subject to maltreatment, misuse, tampering, or unauthorized repair.
- The recasing is to change the case or covering color.

For recasing or replating performed on the same DOS as a major repair, providers should use procedure code V5014 for the major repair and V5014 with modifier "22" for the replating or recasing.

For recasing or replating of the hearing instrument, providers should use procedure code V5014 with modifier "22."

Recasing or replacement of a hearing aid case is covered at a frequency of once per six-month period.

Copayment

Recipients are responsible for paying a copayment for all Wisconsin Medicaid-covered hearing services, except for hearing aid batteries. The copayment schedule is as follows:

Maximum allowable fee, per procedure code	Copayment amount, per date of service
Up to \$10.00	\$0.50
From \$10.01 to \$25.00	\$1.00
From \$25.01 to \$50.00	\$2.00
Over \$50.00	\$3.00

Providers are required to request the copayment amount from recipients; however, they may not deny services to a recipient who fails to make a copayment.

Wisconsin Medicaid copayment amounts should not be deducted from charges submitted to Wisconsin Medicaid, nor should these copayment amounts be indicated in Element 29 (“Amount Paid”) on the CMS 1500 claim form.

Providers are reminded of the following general copayment exemptions:

- Emergency services.
- Hearing aid batteries.
- Services covered by a Medicaid managed care program provided to enrollees of the managed care program.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.

Please refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on recipient copayment requirements.

Diagnosis Codes

All claims require a diagnosis code. All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* coding structure. The diagnosis code must be appropriate for the service provided.

Providers should note the following diagnosis code restrictions:

- Codes with an “E” prefix must not be used as the primary or sole diagnosis on a claim submitted to Wisconsin Medicaid.
- Codes with an “M” prefix are not acceptable on a claim submitted to Wisconsin Medicaid.

CPT and HCPCS Codes

To be eligible for Wisconsin Medicaid reimbursement, all claims for hearing services and hearing instruments submitted to Wisconsin Medicaid must include CPT or Healthcare Common Procedure Coding System (HCPCS) codes that are allowable for the date of service (DOS). Hearing services claims or adjustments received without allowable codes are denied.

Audiologists may submit claims for both CPT and HCPCS codes. For hearing instrument specialists, Wisconsin Medicaid will only reimburse claims for HCPCS codes. Wisconsin Medicaid will not reimburse hearing instrument specialists for claims for CPT codes.

Refer to Appendices 1 and 2 of this handbook for Wisconsin Medicaid-allowable CPT and HCPCS codes. Further explanation on two codes is included below.

Unlisted Audiology Procedure Code 92599

Procedure code 92599 should be used only when *no other* CPT code description appropriately describes the service or

To be eligible for Wisconsin Medicaid reimbursement, all claims for hearing services and hearing instruments submitted to Wisconsin Medicaid must include CPT or Healthcare Common Procedure Coding System (HCPCS) codes that are allowable for the date of service (DOS).

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procedure being performed. Claims for procedure code 92599 (unlisted otorhinolaryngological service or procedure) require documentation describing the procedure performed.

Use of this procedure code always requires PA. Refer to the Prior Authorization chapter of this handbook for more information.

Wisconsin Medicaid individually prices procedure code 92599 based on information provided on the PA request and claim form.

Nonspecific Procedure Code or Repair V5299

HCPCS code V5299 should be used only when there is no other code that describes the item being offered. Use of HCPCS code V5299 always requires PA.

Wisconsin Medicaid individually prices HCPCS code V5299 based on information provided on the PA request and claim form.

Place of Service and Type of Service Codes

All claims for hearing services submitted to Wisconsin Medicaid are required to use allowable place of service (POS) and type of service (TOS) codes to be eligible for Wisconsin Medicaid reimbursement. Refer to Appendix 4 of this handbook for a list of allowable POS and TOS codes for hearing services.

Service Units

For audiology services, one unit of service is the complete service as defined by the CPT code description. The provider's medical records must document that the service was completed on the DOS shown on the claim.

Follow-Up to Claims Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing within 365 days of the DOS.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid.

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A Appendix

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Appendix 1

CPT Codes for Audiology Services

Wisconsin Medicaid will only reimburse audiologists for the services (listed in this appendix) covered by the *Current Procedural Terminology* codes for audiology services.

Note: Indicate type of service code “1” when submitting claims for these procedure codes.

Procedure Code	Description
69210	Removal impacted cerumen (separate procedure), one or both ears
92506*	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507*	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508*	Group, two or more individuals
92510 [†]	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services), with or without speech processor programming
92516	Facial nerve function studies (eg, electroneurography)
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus test
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	Optokinetic nystagmus test
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording

*These services require prior authorization after the initial 35 days per spell of illness, per recipient, per provider. Refer to the Speech-Language Pathology Handbook for more information.

[†]Prior authorization is required for the initial service and all subsequent services.

**Appendix 1
(Continued)**

Procedure Code	Description
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinusoidal vertical axis rotational testing
92547	Use of vertical electrodes (List separately in addition to code for primary procedure) (Use 92547 in conjunction with codes 92541-92546)
92548	Computerized dynamic posturography
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	air and bone
92555	Speech audiometry threshold;
92556	with speech recognition
92557‡	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92559	Audiometric testing of groups
92560	Bekesy audiometry; screening
92561	diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92571	Filtered speech test

‡Not reimbursed if submitted on the same date of service as 92553 or 92556.

**Appendix 1
(Continued)**

Procedure Code	Description
92572	Staggered spondaic word test
92573	Lombard test
92575	Sensorineural acuity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
92589	Central auditory function test(s) (specify)
92590	Hearing aid examination and selection; monaural
92591	binaural
92592	Hearing aid check; monaural
92593	binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	binaural
92599 [†]	Unlisted otorhinolaryngological service or procedure

[†]Prior authorization is required for the initial service and all subsequent services.

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Appendix 2

HCPCS Codes for Hearing Instruments

Wisconsin Medicaid reimburses audiologists and hearing instrument specialists for Healthcare Common Procedure Coding System (HCPCS) codes for hearing instruments and batteries.

Allowable types of service, modifiers, and places of service for audiologists, hearing instrument specialists, and speech and hearing clinics		
Allowable types of service (TOS) (Required)	Allowable modifiers	Allowable places of service (POS)
P — Purchase R — Rental 9 — Other	LT — Left ear RT — Right ear 52 — Minor repairs 22 — Recasing or replating RR — Rental* 50 — Both ears	0 — Other 1 — Inpatient hospital 2 — Outpatient hospital 3 — Office 4 — Home 7 — Nursing home/extended 8 — Skilled nursing facility

Procedure code	Procedure code description	Modifier	TOS	Prior authorization	Life expectancy
V5014	Repair/modification of a hearing aid (major repair)	RT, LT, 50	P	No	6 months
V5014	Recasing or replating hearing aid	22, 50, RT, LT	P	No	6 months
V5014	Minor repair	52, 50, RT, LT	P	No	6 months
V5030	Hearing aid, monaural; body worn, air conduction**	RT, LT, RR	P, R	Yes	3 years
V5040	body worn, bone conduction	RT, LT, RR	P, R	Yes	3 years
V5050	in the ear	RT, LT, RR	P, R	Yes	3 years
V5060	behind the ear	RT, LT, RR	P, R	Yes	3 years
V5070	Glasses; air conduction	RT, LT, RR	P, R	Yes	3 years
V5080	bone conduction	RT, LT, RR	P, R	Yes	3 years
V5100***	Hearing aid, bilateral, body worn	RR	P, R	Yes	3 years
V5110	Dispensing fee, bilateral		P	Yes	

* RR = Rental hearing aid. The maximum allowable fee for all rentals is \$27.34 per 30-day period. All rented hearing instruments require prior authorization (PA). Wisconsin Medicaid does not reimburse providers for dispensing fees for rental hearing instruments.

** All hearing instruments are air conduction unless otherwise noted.

*** Procedure code V5100 is a body worn hearing instrument with two receivers/ear molds and a y-cord.

**Appendix 2
(Continued)**

Procedure code	Procedure code description	Modifier	TOS	Prior authorization	Life expectancy
V5120	Binaural; body	RR*	P, R	Yes	3 years
V5130	in the ear	RR	P, R	Yes	3 years
V5140	behind the ear	RR	P, R	Yes	3 years
V5150	glasses	RR	P, R	Yes	3 years
V5160**	Dispensing fee, binaural		P	Yes	
V5170	Hearing aid, CROS; in the ear	RT, LT, RR	P, R	Yes	3 years
V5180	behind the ear	LT, RT, RR	P, R	Yes	3 years
V5190	glasses	RT, LT, RR	P, R	Yes	3 years
V5200	Dispensing fee, CROS	RT, LT	P	Yes	3 years
V5210	Hearing aid, bicros; in the ear	RR	P, R	Yes	3 years
V5220	behind the ear	RR	P, R	Yes	3 years
V5230	glasses	RR	P, R	Yes	3 years
V5240	Dispensing fee, bicros		P	Yes	3 years
V5241	Dispensing fee, monaural hearing aid, any type	RT, LT	P	Yes	
V5242	Hearing aid, analog, monaural, cic (completely in the ear canal)	RT, LT, RR	P, R	Yes	3 years
V5243	Hearing aid, analog, monaural, itc (in the canal)	RT, LT, RR	P, R	Yes	3 years
V5244	Hearing aid, digitally programmable analog, monaural, cic	RT, LT, RR	P, R	Yes	3 years
V5245	Hearing aid, digitally programmable, analog, monaural, itc	RT, LT, RR	P, R	Yes	3 years
V5246	Hearing aid, digitally programmable analog, monaural, ite (in the ear)	RT, LT, RR	P, R	Yes	3 years
V5247	Hearing aid, digitally programmable analog, monaural, bte (behind the ear)	RT, LT, RR	P, R	Yes	3 years
V5248	Hearing aid, analog, binaural, cic	RR	P, R	Yes	3 years
V5249	Hearing aid, analog, binaural, itc	RR	P, R	Yes	3 years
V5250	Hearing aid, digitally programmable analog, binaural, cic	RR	P, R	Yes	3 years
V5251	Hearing aid, digitally programmable analog, binaural, itc	RR	P, R	Yes	3 years
V5252	Hearing aid, digitally programmable, binaural, ite	RR*	P, R	Yes	3 years

* RR = Rental hearing aid. The maximum allowable fee for all rentals is \$27.34 per 30-day period. All rented hearing instrument require PA. Wisconsin Medicaid does not reimburse providers for dispensing fees for rental hearing instruments.

** When submitting claims for these codes, hearing instrument specialists are required to complete Elements 17 and 17a of the CMS 1500 claim form. Refer to Appendix 16 of this handbook for more information.

Appendix

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**Appendix 2
(Continued)**

Procedure code	Procedure code description	Modifier	TOS	Prior authorization	Life expectancy
V5253	Hearing aid, digitally programmable, binaural, bte	RR	P, R	Yes	3 years
V5254	Hearing aid, digital, monaural, cic	RT, LT, RR	P, R	Yes	3 years
V5255	Hearing aid, digital, monaural, itc	RT, LT, RR	P, R	Yes	3 years
V5256	Hearing aid, digital, monaural, ite	RT, LT, RR	P, R	Yes	3 years
V5257	Hearing aid, digital, monaural, bte	RT, LT, RR	P, R	Yes	3 years
V5258	Hearing aid, digital, binaural, cic	RR	P, R	Yes	3 years
V5259	Hearing aid, digital, binaural, itc	RR	P, R	Yes	3 years
V5260	Hearing aid, digital, binaural, ite	RR	P, R	Yes	3 years
V5261	Hearing aid, digital, binaural, bte	RR	P, R	Yes	3 years
V5264	Ear mold/insert, not disposable, any type	RT, LT, 50	P	No	For recipients under 18 years of age: three ear molds per hearing aid per year For recipients 18 years of age and older: one ear mold per hearing aid per year
V5266	Battery for use in hearing device		9**	No	12 per month
V5267	Hearing aid supplies/accessories	RT, LT, 50	P	Yes	3 years
V5273	Assistive listening device, for use with cochlear implant		P	Yes	1 per 3 years
V5274	Assistive listening device, not otherwise specified		P	Yes	1 per 3 years
V5275	Ear impression, each	RT, LT	P	No	For recipients under 18 years of age: three ear molds per hearing aid per year For recipients 18 years of age and older: one ear mold per hearing aid per year
V5299***	Hearing service, miscellaneous		P	Yes	

- * RR = Rental hearing aid. The maximum allowable fee for all rentals is \$27.34 per 30-day period. All rented hearing instruments require PA. Wisconsin Medicaid does not reimburse providers for dispensing fees for rental hearing instruments.
- ** Submit claims for procedure code V5266 using TOS "9" (Other). Batteries for use in hearing devices are listed in the Disposable Medical Supplies Index.
- *** When submitting claims for these codes, hearing instrument specialists are required to complete Elements 17 and 17a of the CMS 1500 claim form. Refer to Appendix 16 of this handbook for more information.

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Appendix 3

Hearing Instrument Packages, Limitations, and Prior Authorization Requirements

Hearing Instrument or Service	Services/Items Included in Wisconsin Medicaid's Reimbursement	Life Expectancy*	Limitations	Prior Authorization Required?
Monaural hearing aid package.	Wisconsin Medicaid reimburses for: <ul style="list-style-type: none"> • Monaural hearing aid. • One ear mold. • One package of batteries. 	One hearing aid every three years.		Yes.
Binaural hearing aid package.	Wisconsin Medicaid reimburses for: <ul style="list-style-type: none"> • Binaural hearing aid. • Two ear molds. • Two packages of batteries. 	Two hearing aids every three years.		Yes.

*Prior authorization is required for the replacement of any hearing instrument prior to the instrument's life expectancy (e.g., replacing a hearing aid with a life expectancy of three years within one year of purchase).

**Appendix 3
(Continued)**

Hearing Instrument or Service	Items/Services Included in Wisconsin Medicaid's Reimbursement	Life Expectancy*	Limitations	Prior Authorization Required?
Hearing instrument accessories are: <ul style="list-style-type: none"> • Single cord. • Y-cord. • Harness. • New receiver. • Bone conduction receiver with headband. 	Wisconsin Medicaid reimburses for hearing instrument accessories separate from the initial package.	For recipients under age 18: Three earmolds per hearing aid, two single cords per hearing aid, and two Y-cords per recipient per year. For recipients over age 18: One earmold per hearing aid, one single cord per hearing aid, and one Y-cord per recipient per year. For all recipients: One harness, one new receiver per hearing aid, and one bone-conduction receiver with headband per recipient per year.	Ear molds are not separately reimbursable at the time of initial hearing aid purchase.	Only if replaced sooner than life expectancy indicates.
Assistive Listening Device (ALD).	Wisconsin Medicaid reimburses for: <ul style="list-style-type: none"> • One ALD. 	One ALD every three years.	No dispensing fee.	Yes.

*Prior authorization is required for the replacement of any hearing instrument prior to the instrument's life expectancy (e.g., replacing a hearing aid with a life expectancy of three years within one year of purchase).

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**Appendix 3
(Continued)**

Hearing Instrument or Service	Items/Services Included in Wisconsin Medicaid's Reimbursement	Life Expectancy*	Limitations	Prior Authorization Required?
Dispensing of a hearing aid (dispensing fee).	<p>The dispensing fee includes:</p> <ul style="list-style-type: none"> • Initial office visit, ear mold impression and fitting of the proper hearing aid. • One-year warranty. • Up to five post-fitting follow-up office visits as necessary for adjustments and hearing aid orientation. 		<p>A performance check is required to receive Wisconsin Medicaid reimbursement.</p> <p>Wisconsin Medicaid does not reimburse a dispensing fee for:</p> <ul style="list-style-type: none"> • Rented hearing instruments. • Assistive listening devices. 	Yes.
Hearing instrument repairs.	<p>Wisconsin Medicaid reimburses for:</p> <ul style="list-style-type: none"> • Minor repairs. • Major repairs. 	<p>Minor repairs are covered once per six-month period, when performed by the same provider on the same instrument.</p> <p>Major repairs are covered once per twelve-month period, when performed by the same provider on the same instrument.</p>	<p>Wisconsin Medicaid does not reimburse for:</p> <ul style="list-style-type: none"> • Repairs on rented items. • Minor and major repairs provided on the same date of service. • Repairs on items that are covered under warranty. 	Only if replaced sooner than life expectancy indicates.
Recasing or Replacing.	<p>Wisconsin Medicaid reimburses for recasing or replacing of hearing instruments.</p>	<p>Recasing or replacing is covered once per 24 months, per recipient, per provider.</p>	<p>Wisconsin Medicaid will not reimburse for a recasing or replacement unless performed with a major repair.</p>	Only if replaced sooner than life expectancy indicates.

*Prior authorization is required for the replacement of any hearing instrument prior to the instrument's life expectancy (e.g., replacing a hearing aid with a life expectancy of three years within one year of purchase).

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Appendix 4

Place of Service and Type of Service Codes for Audiology and Hearing Instrument Services

Wisconsin Medicaid Allowable Place of Service (POS) Codes	
POS Code	Description
0	Other
2	Outpatient Hospital
1	Inpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
B	Ambulatory Surgical Center

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Wisconsin Medicaid Allowable Type of Service (TOS) Codes	
TOS Code	Description
1*	Medical
9†	Other
P	Purchase New Durable Medical Equipment (DME)
R	Rent DME

*Type of service code “1” should only be used by audiologists. Wisconsin Medicaid will not reimburse claims from hearing instrument specialists that indicate TOS “1.”

†Providers should only indicate TOS “9” when submitting claims for hearing aid batteries.

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Appendix 5

Letter Sent to Recipients Upon Approval of a Prior Authorization Request for a Hearing Instrument

(A copy of the Letter Sent to Recipients Upon Approval of a Prior Authorization Request
for a Hearing Instrument is located on the following page.)

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1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Recipient:

Enclosed are the Wisconsin Medicaid authorization forms for hearing aids that your Audiologist or Hearing Instrument Specialist requested. Please take these forms to the Wisconsin Medicaid certified Audiologist/Hearing Instrument Specialist of your choice. This will allow you to obtain your authorized hearing aid. The Audiologist/Hearing Instrument Specialist will complete the necessary billing forms.

Sincerely,

Wisconsin Medicaid
Prior Authorization Unit

Enclosures

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Wisconsin Medicaid
6406 Bridge Rd
Madison WI 53784
(608) 221-4746

Appendix

Appendix 6

Prior Authorization Request Form (PA/RF) Completion Instructions for Audiology Services

Wisconsin Medicaid requires 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 will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid, and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Therapy Services Attachment (PA/TA), by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

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

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The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Element 1 — Processing Type

Enter processing type 113; this code is for audiology services. The processing type is a three-digit code used to identify a category of service requested.

Element 2 — Recipient's Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 3 — Recipient's Name

Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 6 — Sex

Enter an "X" in the appropriate box to specify whether the recipient is male or female.

Element 7 — Billing Provider Name, Address, Zip Code

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 9. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 9 — Billing Provider No.

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 7.

Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Dx: Secondary

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code

Enter the appropriate procedure code for each service or procedure requested.

Element 15 — MOD

Enter the modifier corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 16 — POS

Enter the appropriate place of service (POS) code designating where the requested service or procedure would be provided/performed/dispensed.

Element 17 — TOS

Enter the appropriate type of service (TOS) code for each service or procedure requested.

Element 18 — Description of Service

Enter a written description corresponding to the appropriate procedure code for each service or procedure requested.

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Element 19 — QR

Enter the appropriate quantity (e.g., number of services) requested for the procedure code listed.

Element 20 — Charges

Enter your usual and customary charge for each service or procedure requested. If the quantity is greater than “1.0,” multiply the quantity by the charge for each service or procedure requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider’s usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved prior 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 Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

Element 23 — Date

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Element 24 — Requesting Provider Signature

The requesting provider’s original signature is required in this element.

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

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Appendix 7

Sample Prior Authorization Request Form (PA/RF)

(A copy of the Prior Authorization Form [PA/RF] is located on the following page.)

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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. # 1234567

1 PROCESSING TYPE

113

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)
**609 Willow
 Anytown, WI 55555**

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:
**Im A. Provider
 555 Circle Dr
 Anytown, WI 55555**

9 BILLING PROVIDER NO.
87654321

10 DX: PRIMARY
389.10 Sensorineural Hearing Loss, Unspecified

11 DX: SECONDARY

12 START DATE OF SOI: _____ 13 FIRST DATE RX: _____

14	15	16	17	18	19	20
PROCEDURE CODE	MOD	POS	TOS	DESCRIPTION OF SERVICE	QR	CHARGES
92506		3	1	Evaluation of Speech and Language	1	XX.XX
92507		3	1	Aural Rehabilitation	6	XX.XX
					21	XXX.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 REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

APPROVED

MODIFIED - REASON: _____

DENIED - REASON: _____

RETURN - REASON: _____

GRANT DATE: _____ EXPIRATION DATE: _____

PROCEDURE(S) AUTHORIZED: _____ QUANTITY AUTHORIZED: _____

482-120 DATE _____ CONSULTANT/ANALYST SIGNATURE _____

Appendix

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Appendix 8

Prior Authorization / Therapy Attachment (PA/TA) Completion Instructions

Wisconsin Medicaid requires 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 shall 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 your 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.

Each provider must submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the recipient to meet Wisconsin Medicaid's definition of "medically necessary." "Medically necessary" is defined in HFS 101.03(96m), Wis. Admin. Code. Each PA request is unique, representing a specific clinical situation. Therapists typically consider a number of issues that influence a decision to proceed with therapy treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. Medicaid therapy consultants will consider documentation of those same factors to determine whether or not the request meets Wisconsin Medicaid's definition of "medically necessary." Medicaid consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

Refer to the Online Handbook

These directions are formatted to correspond to each required element on the Prior Authorization/Therapy Attachment (PA/TA). The bold headers directly reflect the name of the element on the PA/TA. The proceeding text reflects instructions, hints, examples, clarification, etc. that will help the provider document medical necessity in sufficient detail.

Attach the completed PA/TA to the Prior Authorization/Request Form (PA/RF) 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

SECTION I — RECIPIENT / PROVIDER INFORMATION

Enter the following information into the appropriate box:

Element 1 — Name — Recipient (Last, First, Middle Initial)

Enter the recipient's last name, first name, and middle initial. Use Wisconsin Medicaid's Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or the spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Refer to the Provider Resources section of the All-Provider Handbook for ways to access the EVS.

Element 2 — Recipient Medicaid Number

Enter the recipient's 10-digit Medicaid number. Do not enter any other numbers or letters.

Element 3 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 4 — Name and Credentials — Therapist

Enter the treating therapist's name and credentials. If the treating therapist is a therapy assistant, enter the name of the supervising therapist and the name of the therapy assistant.

Element 5 — Therapist's Medicaid Provider No.

Enter the treating therapist's eight-digit Medicaid provider number. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider number.

Element 6 — Telephone No. — Therapist

Enter the treating therapist's telephone number, including area code and extension (if applicable). If the treating therapist is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring / Prescribing Physician

Enter the referring or prescribing physician's name.

Be sure:

- The recipient's name and Medicaid identification number match.
- The recipient's Medicaid identification number has 10 digits.
- The recipient is currently Medicaid eligible.
- The provider's name and Medicaid identification number match.
- The provider's Medicaid number has eight digits.

Note: All of this information in this section must be complete, accurate, and exactly the same as the information from Medicaid's EVS and on the PA/RF before your PA request is forwarded to a Medicaid consultant. Incomplete or inaccurate information will result in a returned PA request.

Element 8 — Requesting Prior Authorization For Physical Therapy, Occupational Therapy, Speech and Language Pathology

Check the appropriate box on the PA/TA for the type of therapy service being requested.

Element 9 — Total Time Per Day Requested

Enter the anticipated number of minutes a typical treatment session will require. It is expected the requested minutes per session will be consistent with the recipient's history, age, attention span, cognitive ability, medical status, treatment goals, procedures, rehabilitation potential, and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 10 — Total Sessions Per Week Requested

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Enter the number of treatment days per week requested. It is expected the requested number of treatment days per week will be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential, and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 11 — Total Number of Weeks Requested

Enter the number of weeks requested. The requested duration should be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential, and any other intervention the recipient receives. The requested duration **SHOULD CORRESPOND TO THE NUMBER OF WEEKS REQUIRED TO REACH THE GOALS IDENTIFIED IN THE PLAN OF CARE (POC)**. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 12 — Requested Start Date

Enter the requested grant date for this PA request in MM/DD/YYYY format.

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

Element 13 — INSTRUCTIONS: Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Indicate the pertinent medical diagnoses that relate to the reasons for providing therapy for the recipient at this time **AND** any underlying conditions that may affect the POC or outcome (e.g., dementia, cognitive impairment, medications, attention deficits). Include dates of onset for all diagnoses. If the date of onset is unknown, state "unknown."

If this documentation is on a previous PA request and is still valid, indicate "this documentation may be found on PA No. XXXXXXXX." Providers should review this information for accuracy each time that they submit a PA request.

Note: Avoid copying the same information on subsequent PA requests without verifying that the information continues to be accurate. A PA request may be returned if it appears as if there has been no change documented under Section II, but other sections of the PA suggest there have been some changes to the recipient's medical/functional condition/need.

Example 1: A recipient without cognitive impairment may attain a goal to learn a task in one to three visits. However, achieving the same treatment goal for a cognitively impaired recipient may require additional visits. Knowledge of the recipient's cognitive abilities is critical to understanding the need for the requested additional visits.

Example 2: When the recipient has a medical diagnosis, such as Parkinson's disease or pervasive developmental disorder, it is necessary to document the medical diagnosis **AS WELL AS** the problem(s) being treated. Listing problem(s) to be treated without a medical diagnosis, or vice versa, is insufficient.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

Element 14 — INSTRUCTIONS: Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

The Medicaid consultant needs to understand the complete “picture” of the recipient and takes into consideration the recipient’s background, personal needs, status, change in status, etc. Sufficient, but pertinent, documentation of a recipient’s medical/social status may include:

- Conditions that may affect the recipient’s outcome of treatment.
- Evidence that this recipient will benefit from therapy at this time.
- Reasons why a Medicaid-reimbursed service is being requested at this time (this is helpful when this is not a new diagnosis or is a continuing episode of care for this recipient).

The provider’s documentation must include the factors considered when developing the recipient’s POC. Such factors may be:

- Reasons for referral.
- Referral source (e.g., a second opinion, nursing having difficulty with carry-over program, school therapist referred because school does not have equipment to make orthotics).
- Reason(s) the recipient’s medical needs are not met under current circumstances.
- Recent changes (e.g., change in medical status, change in living status) with reference dates.
- Recipient’s goal (e.g., recipient’s motivation to achieve a new goal may have changed).
- Recipient’s living situation.
- Residence (e.g., nursing home vs. independent living).
- Caregiver (who is providing care [specific name not required], how frequently available, ability to follow through with instructions, etc.).
- If caregiver is required — the level of assistance required, the amount of assistance required, the type of assistance required.
- Degree of family support.
- Equipment and/or environmental adaptations used by the recipient.
- Brief history of the recipient’s previous functional status.
- Prior level of function.
- Level of function after last treatment episode with reference dates.
- Cognition/behavior/compliance.
- Any other pertinent information that indicates a need for therapy services at this time.

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for current policy

SECTION IV — PERTINENT THERAPY INFORMATION

Element 15 — INSTRUCTIONS: Document the chronological history of treatment provided for the treatment diagnoses (identified under “II”), dates of those treatments, and the recipient’s functional status following those treatments.

Summarize previous episodes of care, if applicable, in the chart provided in this section. If this is a new patient, include history taken from the recipient, recipient’s caregivers, or patient file. Include knowledge of other therapy services provided to the recipient (e.g., if requesting a PA for speech and language pathology, include any occupational therapy or physical therapy (PT) the recipient may have received as well). Be concise, but informative.

Element 16 — INSTRUCTIONS: List other service providers that are currently accessed by the recipient for treatment diagnoses identified under “II,” (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the

coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.

Document the coordination of the therapy treatment plan with other service providers that may be working to achieve the same, or similar, goals for the recipient. If there are no other providers currently treating the recipient, indicate “not applicable” in the space provided.

Element 17 — INSTRUCTIONS: Check the appropriate box (on the PA/TA) and circle the appropriate form, if applicable:

- The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.**
- The current IEP/IFSP/IPP is attached to PA Number _____.**
- There is no IEP/IFSP/IPP because _____.**
- Co-treatment with another therapy provider is within the POC.**
- Referenced report(s) is attached (list any report[s]) _____.**

The IEP, IFSP, and IPP are reports used as follows:

- Individualized Education Plan — A written plan for a 3- to 21-year-old child who receives exceptional education services in school.
- Individualized Family Service Plan — A written plan for a 0- to 3-year-old child who receives therapy services through the Birth to Three Program.
- Individualized Program Plan — A written active treatment plan for individuals who reside in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

Submission of the IEP, IFSP, and IPP with the PA request is required if the recipient is receiving services that require one of the above written plans.

This section is included as a quick reference to remind providers to attach the necessary documentation materials to the PA request and to remind providers to document cotreatment, if applicable, in their POC.

Cotreatment is when two therapy types provide their respective services to one recipient during the same treatment session. For example, occupational therapists and physical therapists treat the recipient at the same time or occupational therapists and speech-language pathologists treat the recipient at the same time. It is expected the medical need for cotreatment be documented in both providers’ plans of care and both PA requests are submitted *in the same envelope*.

Other “referenced reports” may be swallow studies, discharge summaries, surgical reports, dietary reports, psychology reports, etc. These reports should be submitted with the PA request when the information in those reports influenced the provider’s treatment decision making and were referenced elsewhere in the PA request. PA requests submitted without the required or referenced documentation attached to the PA request will be returned to the provider.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT’S FUNCTIONAL LIMITATIONS)

Element 18 — INSTRUCTIONS: Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- Comprehensive initial evaluation attached. Date of initial comprehensive evaluation** _____.
- Comprehensive initial evaluation submitted with PA number** _____.
- Current re-evaluation attached. Date of most current evaluation or re-evaluation(s)** _____.
- Current re-evaluation submitted with PA number** _____.

A copy of the comprehensive evaluation for the current episode of care (for the current problem being treated) must be included with the PA request or submitted previously with another PA request, regardless of when treatment was initiated, and regardless of the reimbursement source at the time of the comprehensive evaluation. An evaluation defining the recipient's overall functional abilities and limitations with baseline measurements, from which a POC is established, is necessary for the Medicaid consultant to understand the recipient's needs and the request.

The initial evaluation must:

(1) Establish a baseline for identified limitations — Provide baseline measurements that establish a performance (or ability) level, *using units of objective measurement that can be consistently applied when reporting subsequent status*. It is very important to use consistent units of measurement throughout documentation, or be able to explain why the units of measurement changed.

Example 1: If the functional limitation is “unable to brush teeth,” the limiting factor may be due to strength, range of motion, cognition, sensory processing, equipment needs, etc. The baseline should establish the status of identified limiting factors. Such factors may include:

- Range of motion measurements in degrees.
- Eye-hand coordination as measured by a testing tool or units of speed and accuracy.
- Oral sensitivity as measured by an assessment tool or type of reaction to specific kinds of textures or temperatures at specific oral cavity/teeth location.
- Grasp deficits including type of grasp and grip strength.

Later on, subsequent progress must be described using the same terms (e.g., grip strength increased by two pounds).

Example 2: If the functional limitation is “unable to sit long enough to engage in activities,” indicate “the recipient can short sit for two minutes, unsupported, before losing his balance to the left.” Later on, progress can be documented in terms of time.

(2) Relate the functional limitations to an identified deficit — The evaluation must be comprehensive enough that another, independent clinician would reasonably reach the same conclusion regarding the recipient's functional limitation.

Example 1: The recipient is referred to therapy because “she doesn't eat certain types of foods.” The evaluation should clearly indicate the reason for not eating those certain foods. A deficit has not been identified if testing indicates the recipient only eats Food “B.” Some deficit examples (for not eating a variety of foods) are: cleft palate, oral defensiveness, lip closure, tongue mobility, an aversion to food, aspiration, attention span, recipient is G-tube fed and is therefore not hungry. The identified deficit must be objectively measured and quantified (i.e., a baseline — see above).

Example 2: The recipient is referred to therapy because “he cannot go up and down stairs safely.” The evaluation should clearly indicate the reasons for this functional limitation. A deficit has not been identified if the results of testing indicate the recipient can only step up three inches. Strength, range of motion, balance, sensory processing, motivation, etc., must be assessed and documented to identify the deficit causing the functional limitation (i.e. objectively tested, measured, and quantified on the evaluation).

A re-evaluation is the process of performing selected tests and measures (after the initial evaluation) in the targeted treatment area(s) to evaluate progress, functional ability, treatment effectiveness, and/or to modify or redirect intervention. The re-evaluation must be submitted with the PA request whenever it is necessary to update the recipient’s progress/condition. Use of the same tests and measurements as used in the initial evaluation is essential to review status/progress. If new tests or measurements are used in the re-evaluation, explain why a different measurement tool was used.

SECTION VI — PROGRESS

Element 19 — INSTRUCTIONS: Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, since treatment was initiated or last authorized.

(If this information is concisely written in other documentation prepared for your records, attach and write “see attached” in the space.)

Document the goal or functional limitation in the left column on the PA/TA. Indicate the corresponding status for that goal or limitation *as of the previous PA request or since treatment was initiated (whichever is most recent)* in the middle column on the PA/TA. Indicate the corresponding status of that goal or limitation *as of the date of the current PA request* (do not use “a month ago” or “when last seen” or “when last evaluated”) in the third column of the PA/TA. Progress relates to the established baseline, previous goals, and identified limitations. Use the same tests and measurements as those units of measurement used in the baseline description.

The following information is necessary to evaluate the medical necessity of the PA request:

- Progress documented in specific, measurable, objective terms.
- Use of words that are specific, measurable, or objective words such as: better, improved, calmer, happier, pleasant, less/more, not as good, not as reliable, longer, more prolonged, and “goal not met” are not specific, measurable, or objective. These do not convey to the Medicaid consultant if or how much progress has been achieved. The following examples are specific, measurable and objective:

Example 1: Strength increased from POOR to FAIR, as determined with a Manual Muscle Test.

Example 2: Speech intelligibility improved from 30% to 70%, per standardized measurement.

- Consistent use of the same tests and measurements and units of measurement.

Example: A progress statement that notes the recipient can now eat hamburgers does not correlate to his goal of articulation and the baseline established for articulation.

- Progress must demonstrate the recipient has learned new skills and therefore has advanced or improved in function as a result of treatment intervention. *“If treatment of underlying factors, such as increase in endurance, strength or range of motion or decrease in pain does not improve the performance of functional activities, then improvement is not considered to be significant.” (Acquaviva, p. 85).*

“Significant functional progress: Must result from treatment rather from maturation or other uncontrolled factors, must be real, not random, must be important, not trivial” (Bain and Dollaghan).

- Significant functional progress must have been demonstrated within the past six months for continued therapy PA approval. Prior authorization requests for treatment when the recipient has not advanced or improved function within six months cannot be approved, HFS 107.16(3)(e)1, HFS 107.17(3)(e)1, and HFS 107.18(3)(e)1, Wis. Admin. Code.
- Prior authorization requests for maintenance therapy must demonstrate the functional purpose (medical necessity) of treatment, as “progress” is not necessarily applicable to maintenance programs. The Medicaid consultant will look for evidence that there is a continued functional purpose for the recipient as a result of skilled therapeutic intervention, in accordance with the Wisconsin Administrative Code and applicable *Wisconsin Medicaid and BadgerCare Updates*.

SECTION VII — PLAN OF CARE

Element 20 — INSTRUCTIONS: Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and

- (1) the therapist-required skills/treatment techniques that will be used to meet each goal; and
- (2) designate (with an asterisk[*]) which goals are reinforced in a carry-over program.

(If the POC is concisely written in other documentation prepared for the recipient’s records, attach and write “see attached” in the space provided.)

Examples for this section include:

1. GOAL: Client will be 80% intelligible in conversation as judged by an unfamiliar listener.
POC: Oral motor exercises, environmental cues, articulation skills.
2. GOAL: Client will increase vocabulary with five new words as reported by parent.
POC: Sing songs, read books, use adjectives and adverbs in conversation.*
3. GOAL: Client will ascend stairs reciprocally without assistance.
POC: Gastrocnemius and gluteus medius strengthening.
4. GOAL: Client will transfer into and out of tub with verbal cues.
POC: Prepare bathroom and client for transfer, provide consistent verbal cues as rehearsed in PT.*
5. GOAL: Client will demonstrate ability to button ½-inch button on dress shirt independently using any pinch pattern.
POC: Graded finger grasp/pinch strengthening, eye-hand coordination, and bilateral hand use.
6. GOAL: Client will catch/throw a 10” ball.
POC: Practice play catch while sitting using a variety of objects, e.g., Nerf ball, plastic ball, beach ball, volleyball, balloon.*

It is very important to:

- Use consistent units of measurement.
- Document those elements of a treatment plan that only a skilled therapist could implement (e.g., 1, 3, and 5 above).
- Designate (with an asterisk [*]) those goals or interventions you have instructed other caregivers or the recipient to incorporate into the recipient’s usual routine in their usual environment (such as 2, 4, and 6 above where kicking a ball, jumping, throwing a ball, building endurance, rote activities, who/what/where questions, using appropriate pronouns, choosing new foods, etc., are part of the overall POC).
- Write goals consistent with functional limitations and identified deficit as described in the evaluation and status statements (Section V) or progress section (Section VI).

Example: The evaluation identified the functional limitation and deficits corresponding to the above examples. Examples of limitations and deficits may include:

1. The client is not intelligible in conversation due to poor tongue control.
2. The 24-month-old client cannot express his needs because he has the vocabulary of a 16-month-old.
3. The client cannot get to his bedroom independently because of POOR muscle strength.
4. The client cannot safely get into the bathtub because he has poor short-term memory and is easily distractible.
5. The client cannot dress independently because of decreased fine-motor skills as tested on the Peabody and he lacks all functional pinch patterns.
6. The client cannot use hands/arms bilaterally because of poor left upper-extremity proximal stability.

SECTION VII — REHABILITATION POTENTIAL

Element 21 — INSTRUCTIONS: Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

Describe what the recipient will be able to FUNCTIONALLY DO at the end of this episode of care (not necessarily the end of the PA request), based upon the professional assessment. Discharge planning begins at the initial evaluation. At the initial evaluation the therapist should be able to determine the amount/type of change the recipient is capable of making based upon all the factors presented at the evaluation. Statements such as “will be age appropriate,” “will resume prior level of function,” “will have effects of multiple sclerosis minimized,” or “will eat all foods” are vague and frequently are not achievable with the patient population therapists encounter. More recipient-specific or definitive statements of prognosis would be the following examples:

- “Return to home to live with spouse support.”
- “Communicate basic needs and wants with her peers.”
- “Go upstairs to his bedroom by himself.”
- “Get dressed by herself.”
- “Walk in the community with standby assistance for safety.”
- “Walk to the dining room with or without assistive device and the assistance of a nurse’s aide.”
- “Swallow pureed foods.”

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

Indicate what community or therapy services the recipient may continue to require at the end of this episode of care. Examples include:

- “Range of motion program by caregivers.”
- “Infrequent (be specific) screening by therapist to assure maintenance of skills.”
- “A communication book.”
- “Behavior management services.”
- “Dietary consultation.”
- “Supervision of <a task> by a caregiver.”

(3) The recipient/recipient's caregivers support the therapy POC by the following activities and frequency of carryover

Describe what activities the recipient and/or caregivers do/do not do with the recipient that will affect the outcome of treatment.

(4) It is estimated this episode of care will end (provide approximate end time)

Establish an anticipated time frame for the recipient to meet his/her realistic functional goals (e.g., two weeks, two months, two years).

These specific questions are asked to avoid one-word responses (e.g., "good"). Information beyond a one-word response provides the Medicaid consultant with additional detail that supports the justification that therapy services are necessary to meet the recipient's goals. Wisconsin Medicaid recognizes the statements in this section are considered professional judgments and may not reflect the actual outcome of treatment.

Element 22 — SIGNATURE — Physician

The providing therapist's signature is required at the end of the PA/TA.

Element 23 — Date Signed

Enter the month, day, and year the PA/TA was signed (in MM/DD/YYYY format).

Element 24 — SIGNATURE — Recipient or Recipient Caregiver (optional)

The recipient's, or recipient's caregiver's, signature is optional at this time, but is encouraged (as a means to review what has been requested on the recipient's behalf on the PA request).

Element 25 — Date Signed

Enter the month, day, and year the PA/TA was signed (in MM/DD/YYYY format). If the required documentation is missing from the request form, the request is returned to the provider for the missing information.

REMINDER: The PA/RF must be filled out completely (i.e., all sections completed). Attach the completed PA/TA and any other documentation to the PA/RF.

REFERENCES

- Bain and Dollaghan (1991). Language, Speech and Hearing Services in Schools, 13
- Acquaviva, J.D., ed. (1992). Effective Documentation for Occupational Therapy. Rockville, Maryland, The American Occupational Therapy Association, Inc.
- Moyers, P.A. (1999). "The Guide to Occupational Therapy Practice." American Journal of Occupational Therapy (Special Issue), 53 (3)
- American Physical Therapy Association, 2001, Guide to Physical Therapist Practice, Physical Therapy, 81 (1)
- American Physical Therapy Association, 1997, Guide to Physical Therapist Practice, Physical Therapy, 77 (11)
- American Speech-Language and Hearing Association, 1997, Cardinal Documents
- American Occupational Therapy Association Standards of Practice
- American Physical Therapy Association Standards of Practice
- American Speech-Language and Hearing Association Standards of Practice
- Wisconsin Administrative Code

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Refer to the Online Handbook
for current policy

Appendix 9

Prior Authorization / Therapy Attachment (PA/TA)

(The Prior Authorization/Therapy Attachment [PA/TA] is located on the following pages.)

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for current policy

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION/THERAPY ATTACHMENT (PA/TA)**

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/Therapy Attachments (PA/TA) Completion Instructions (HCF 11008A).

SECTION I — RECIPIENT / PROVIDER INFORMATION

1. Name — Recipient (Last, First, Middle Initial)		2. Recipient Medicaid Number	3. Age — Recipient
4. Name and Credentials — Therapist		5. Therapist's Medicaid Provider No.	6. Telephone No. — Therapist
7. Name — Referring / Prescribing Physician		8. Requesting PA for <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech and Language Pathology	
9. Total Time Per Day Requested		10. Total Sessions Per Week Requested	
11. Total Number of Weeks Requested		12. Requested Start Date	

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

13. **INSTRUCTIONS:** Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

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SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

14. **INSTRUCTIONS:** Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION IV — PERTINENT THERAPY INFORMATION

15. **INSTRUCTIONS:** Document the chronological history of treatment for the diagnoses (identified under Section II), dates of those treatments, and the recipient's functional status following those treatments.

Provider Type (e.g., OT, PT, ST)	Dates of Treatment	Functional Status after Treatment

Continued

SECTION IV — PERTINENT THERAPY INFORMATION (Continued)

16. **INSTRUCTIONS:** List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under "II", (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.

17. **INSTRUCTIONS:** Check the appropriate box and circle the appropriate form, if applicable.

- The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/Individual Program Plan (IPP) is attached to this PA request.
- The current IEP/IFSP/IPP is attached to PA Number _____.
- There is no IEP/IFSP/IPP because _____.
- Cotreatment with another therapy provider is within the plan of care (POC).
- Referenced report(s) is attached (list any report[s]) _____.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

18. **INSTRUCTIONS:** Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- Comprehensive initial evaluation submitted with PA number _____.
- Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- Current re-evaluation submitted with PA number _____.

SECTION VI — PROGRESS

19. **INSTRUCTIONS:** Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date (/ /)	Status as of Date of PA Request / Date (/ /)
-------------------	-----------------------------------	---

(If this information is concisely written in other documentation prepared for your records, attach and write "see attached" in the space above.)

Continued

SECTION VII — PLAN OF CARE

20. **INSTRUCTIONS:** Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and
- (1) the therapist-required skills/treatment techniques that will be used to meet each goal; and
 - (2) designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the POC is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space above.)

SECTION VIII — REHABILITATION POTENTIAL

21. **INSTRUCTIONS:** Complete the following sentences based upon the professional assessment.
- (1) Upon discharge from this episode of care, the recipient will be able to

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for current policy

-
- (2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

-
- (3) The recipient/recipient's caregivers support the therapy POC by the following activities and frequency of carryover

-
- (4) It is estimated this episode of care will end (provide approximate end time)

22. **SIGNATURE** — Providing Therapist

23. Date Signed

24. **SIGNATURE** — Recipient or Recipient Caregiver (optional)

25. Date Signed

Appendix 10

Prior Authorization Request Form Physician Otological Report (PA/POR) Completion Instructions

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

Element 1 — Physician Name, Address

Enter the requesting physician's name and complete address (street, city, state, and ZIP Code).

Element 2 — Evaluation Date

Enter the date the recipient was examined by the physician in MM/DD/YYYY format (e.g., 05/22/2002).

Element 3 — Physician's Signature and Date

The physician's signature must appear in this element. Enter the month, day, and year (in MM/DD/YYYY format) the form was completed and signed.

Element 4 — Physician's UPIN, Medicaid, or License Number

Enter the physician's eight-digit Medicaid provider number, six-character Medicare Universal Provider Identification Number (UPIN), or license number. If the UPIN is not available, enter the Medicaid provider number or license number of the referring provider.

Element 5 — Physician's Telephone Number

Enter the requesting physician's telephone number, including the area code of the office, clinic, facility, or place of business.

Element 6 — Recipient's Medicaid ID Number

Enter the recipient's 10-digit Wisconsin Medicaid identification number.

Element 7 — Sex

Enter an "X" to specify whether the recipient is male or female.

Element 8 — Recipient Address

Enter the complete address, (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or other facility.

Element 9 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

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Element 10 — Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format.

Element 11 — Medical History of Hearing Loss

Enter the recipient's medical history of hearing loss (if any).

Element 12 — Pertinent Otological Findings

Enter an "X" in the appropriate box(es) and describe all problems.

Element 13 — Additional Findings

Describe any additional findings not covered in Element 11.

Element 14 — Clinical Diagnosis of Hearing Status

Enter the diagnosis of the recipient's hearing status.

Element 15 — Medical, Cognitive, or Developmental Problems

Describe any medical cognitive or developmental problems of the recipient.

Element 16 — Physician's Recommendations

Enter an "X" in the appropriate box(es) to indicate the physician's recommendations.

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Appendix 11

Sample Prior Authorization Request Form Physician Otological Report (PA/POR)

(A copy of the Prior Authorization Request Form Physician Otological Report [PA/POR]
is located on the following page.)

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Refer to the Online Handbook
for current policy

PAPOR
DO NOT DETACH

WISCONSIN MEDICAID FORM PA/POR
PRIOR AUTHORIZATION REQUEST FORM
PHYSICIAN OTOLOGICAL REPORT

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

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

1 PHYSICIAN NAME, ADDRESS (STREET, CITY, STATE, ZIP CODE) Im A Physician 222 Oak Ave Anytown, WI 55555		2 EVALUATION DATE 01/07/2002 MM/DD/YYYY	3 PHYSICIAN'S SIGNATURE AND DATE <u>J.M. Provider</u> M.D. 01/07/2002 SIGNATURE MM/DD/YYYY
6 RECIPIENT'S MEDICAID ID NUMBER 1234567890		4 PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER X12345	5 PHYSICIAN'S TELEPHONE NUMBER (XXX)XXX-XXXX
8 RECIPIENT'S NAME (LAST, FIRST, M.I.) AS ON MEDICAID ID CARD Recipient Im A.		7 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	6 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555
9 RECIPIENT'S DATE OF BIRTH MM/DD/YYYY		10 DATE OF BIRTH MM/DD/YYYY	

11 MEDICAL HISTORY OF HEARING LOSS

12 PERTINENT OTOLOGICAL FINDINGS		NORMAL (Check below)	PROBLEMS (Describe)	13 ADDITIONAL FINDINGS e.g. results of special studies, such as caloric and postural tests (describe):
RIGHT	Canal	<input checked="" type="checkbox"/>	_____	
	Ear Drum	<input checked="" type="checkbox"/>	_____	
	Middle Ear	<input checked="" type="checkbox"/>	_____	
LEFT	Canal	<input checked="" type="checkbox"/>	_____	
	Ear Drum	<input checked="" type="checkbox"/>	_____	
	Middle Ear	<input checked="" type="checkbox"/>	_____	

14 CLINICAL DIAGNOSIS OF HEARING STATUS
Hearing Loss

15 MEDICAL, COGNITIVE, OR DEVELOPMENTAL PROBLEMS

16 PHYSICIAN'S RECOMMENDATIONS (Check all applicable)

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

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

- The patient is 21 years of age or under.
- The patient is behaviorally or cognitively impaired.
- The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.

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

A home hearing test may be required.

PRIOR AUTHORIZATION UNIT

Appendix

Appendix 12

Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) Completion Instructions

Element 1 — Testing Center Name and Address

Enter the testing center's name and complete address (street, city, state, and ZIP code).

Element 2 — Testing Center Provider No.

Enter the testing center's eight-digit Medicaid provider number.

Element 3 — Testing Center Telephone No.

Enter the testing center's telephone number, including area code.

Element 4 — Requesting HIS or Audiologist Name

Enter the hearing instrument specialist's or audiologist's name.

Element 5 — Requesting HIS or Audiologist Provider Number

Enter the requesting hearing instrument specialist's or audiologist's eight-digit Medicaid provider number.

Element 6 — Recipient's Medicaid ID Number

Enter the recipient's 10-digit Wisconsin Medicaid identification number.

Element 7 — Recipient's Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., 09/25/1975).

Element 8 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Referring Physician's Name

Enter the referring physician's name.

Element 10 — Referring Physician's UPIN, Medicaid, or License Number

Enter the physician's eight-digit Medicaid provider number, six-character Medicare Universal Provider Identification Number (UPIN), or license number. If the UPIN is not available, enter the Medicaid provider number or license number of the referring provider.

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Element 11 — Recipient's Address

Enter the complete address (street, city, state, and ZIP Code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or other facility.

Element 12 — Diagnosis

Enter an *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code and written description of the recipient's diagnosis.

Element 13 — POS

Enter the appropriate place of service (POS) code. Refer to Appendix 4 of this handbook for allowable POS codes.

Element 14 — TOS

Enter the appropriate type of service (TOS) code. Refer to Appendix 4 of this handbook for allowable TOS codes.

Element 15 — Procedure Code

Enter the appropriate procedure code for the hearing instrument requested.

Element 16 — Description

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

Element 17 — Quantity

Enter the quantity to be dispensed.

Element 18 — Charge

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

Element 19 — Total Charges

Enter the total of all charges.

Element 20 — Signature

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

Element 21 — Provider Type

Indicate if the provider is an audiologist or hearing instrument specialist.

Element 22 — Date

Enter the date the requesting audiologist or hearing instrument specialist signed the request.

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for current policy

Appendix 13

Sample Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1)

(A copy of the Prior Authorization Request for Hearing Instrument and Audiological Services [PA/HIAS1]
is located on the following page.)

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Refer to the Online Handbook
for current policy

DO NOT DETACH

WISCONSIN MEDICAID FORM PA/IAS1

PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES

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

(DO NOT WRITE IN THIS SPACE)

PROCESSING TYPE **123**

ICN#
 A.T.#
 P.A.# 87654321

1 TESTING CENTER NAME AND ADDRESS Ima Testing Center 222 Oak Ave Anytown, WI 55555		2 TESTING CENTER PROVIDER NO. 12345678	3 TESTING CENTER TELEPHONE NO. (XXX) XXX-XXXX
6 RECIPIENT'S MEDICAID ID NUMBER 1234567890		7 RECIPIENT'S DATE OF BIRTH MM/DD/YYYY	
8 RECIPIENT'S NAME (LAST, FIRST, MI.) AS ON MEDICAID CARD. Recipient Im A.		4 REQUESTING HIS OR AUDIOLOGIST NAME Im A. Audiologist	
11 RECIPIENT'S ADDRESS 609 Willow Anytown, WI 55555		5 REQUESTING HIS OR AUDIOLOGIST PROVIDER NUMBER 87654321	
		9 REFERRING PHYSICIAN'S NAME I. M. Provider	
		10 REFERRING PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER X12345	
		12 DIAGNOSIS 389.10 Sensorineural Hearing Loss	

REQUESTED SERVICES

13 POS	14 TO5	15 PROCEDURE CODE	16 DESCRIPTION (NOT BRAND NAME)	17 QUANTITY	18 CHARGE
3	P	V5252	Programmable Binaural ITE Aids	1	\$XXX.XX
3	P	V5160	Binaural Dispensing Fee	1	\$XXX.XX
TOTAL CHARGES					\$XXX.XX

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

20 Im A. Audiologist
 SIGNATURE

31 PROVIDER TYPE (CHECK ONE)
 AUDIOLOGIST
 HEARING INSTRUMENT SPECIALIST

33 11/15/2002
 MMDDYYYY

FOR COMPLETION BY MEDICAID AUDIOLOGY CONSULTANT

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

MODIFIED — REASON:

DENIED — REASON:

RETURN — REASON:

 SIGNATURE OF MEDICAID AUDIOLOGY CONSULTANT DATE

 PRIOR AUTHORIZATION UNIT

Appendix

Appendix 14

Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2) Completion Instructions

Element 1 — Provider Number

Enter the eight-digit Medicaid provider number of the requesting audiologist or hearing instrument specialist.

Element 2 — Provider Name, Address, ZIP Code

Enter the requesting hearing instrument specialist's or audiologist's name and complete address (street, city, state, and ZIP Code).

Element 3 — Telephone Number

Enter the requesting hearing instrument specialist's or audiologist's telephone number, including area code.

Element 4 — Recipient's Medicaid ID Number

Enter the recipient's 10-digit Wisconsin Medicaid identification number.

Element 5 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 6 — Testing Date

Enter the date, in MM/DD/YYYY format, of the audiological testing/evaluation.

Element 7 — Test Reliability

Circle the proper reliability of the test.

Element 8 — Sex

Enter an "X" to specify whether the recipient is male or female.

Element 9 — Recipient's Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format.

Element 10 — Has the Recipient Ever Used a Hearing Instrument?

Enter an "X" in the appropriate box.

Element 11 — Describe Prior Hearing Instrument Use

Describe the recipient's prior hearing instrument use.

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Elements 12-14 — Audiological Studies or Hearing Tests

Document all audiological testing and results.

Element 15 — Recommendations for a Hearing Instrument

Describe recommendations for a hearing instrument.

Element 16 — Signature

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

Element 17 — Provider Type

Indicate if the provider is a hearing instrument specialist or an audiologist.

Element 18 — Date

Enter the date the requesting hearing instrument specialist or audiologist signed the request.

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for current policy

Appendix 15

Sample Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS2)

(A copy of the Prior Authorization Request for Hearing Instrument and Audiological Services [PA/HIAS2] is located on the following page.)

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for current policy

WISCONSIN MEDICAID FORM PA/HIAS2
PRIOR AUTHORIZATION REQUEST FOR
HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES

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

1 PROVIDER NUMBER
87654321

2 PROVIDER NAME, ADDRESS, ZIP CODE
Ima Hearing Instrument Specialist
222 Oak Ave
Anytown, WI 55555

3 TELEPHONE NUMBER
(XXX) XXX-XXXX

4 RECIPIENT'S MEDICAID ID NUMBER
1234567890

5 RECIPIENT'S NAME (LAST, FIRST, MI.) AS ON MEDICAID ID CARD
Recipient Im A.

6 TESTING DATE
11/15/2002
MM/DD/YYYY

7 TEST RELIABILITY (CIRCLE ONE)
GOOD FAIR POOR

8 SEX
M F

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

10 HAS THE RECIPIENT EVER USED A HEARING INSTRUMENT?
 Yes No

11 DESCRIBE PRIOR HEARING INSTRUMENT USE
Binaural ITE aids acquired in 1996. Both aids malfunctioning, distortion and insufficient gain.

Legend

Ear	Color	Air		Bone		NA
		Un masked	Masked	Un masked	Masked	
Right	Red	o - o	△ - △	o	∩	↙
Left	Blue	x - x	□ - □	o	∩	↘

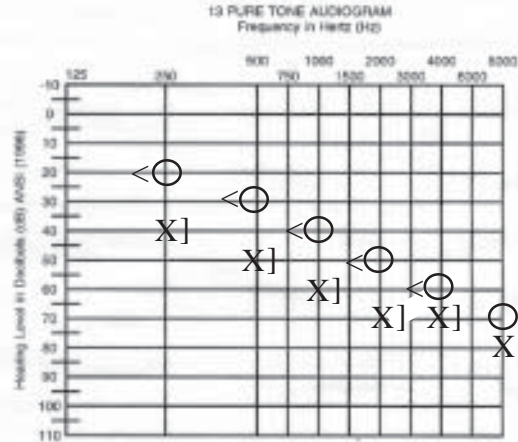
Aided

Own Aid

Test Aid

12 SPEECH AUDIOMETRY

	R	L	SF
Threshold (BRT)	40	60	
Word recognition in quiet	76	66	
Word recognition in noise	DNT	DNT	
Uncomfortable level (dB-HL)	100+	100+	
Most comfortable level (dB-HL)	80	90	



*DNT = Did Not Test

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

14 Tymanometry WNL AU.

15 RECOMMENDATIONS FOR A HEARING INSTRUMENT

EAR: (CHECK ONE) LEFT RIGHT BOTH

STYLE: Full Shell ITE

DESCRIBE ELECTROACOUSTIC SPECIFICATIONS:

DESCRIBE OR ATTACH PERTINENT SOCIAL BACKGROUND AND OTHER RELEVANT INFORMATION:

Recipient lives independently, drives car, and takes care of young grandchildren on a regular basis. Accustomed to binaural amplification. Requires binaural for safety (sound localization) and effective communication in noisy environments.

Ima Hearing Instrument Specialist

16 SIGNATURE

EAR MOLD STYLE:

EAR MOLD LEFT RIGHT BOTH

SPECIAL MODIFICATIONS:

Analog, programmable, compression, telecoil

17 PROVIDER TYPE (CHECK ONE)

AUDIOLOGIST
 HEARING INSTRUMENT SPECIALIST

11/15/2002

18 DATE (MM/DD/YYYY)

PRIOR AUTHORIZATION UNIT

Appendix

Appendix 16

CMS 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should *always* verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator

Enter the appropriate claim sort indicator (noted below) in the Medicaid check box for the service billed.

Provider Type	Type of Service	Claim Sort Indicator
Audiologist	Audiologist services	T
Audiologist	Servicing and supplying of hearing aids	D
Hearing Instrument Specialist	Servicing and supplying of hearing aids	D

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., June 30, 1975, would be 06/30/75) or in MM/DD/YYYY format (e.g., June 30, 1975, would be 06/30/1975). Specify if the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Appendix 16 (Continued)

Element 9 — Other Insured's Name

Third-party insurance (commercial health insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid:

- When the recipient has no commercial health insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), TriCare (“CHA”), or some other (“OTH”) commercial health insurance, **and** the service requires third-party billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code Description

OI-P PAID by commercial health insurance. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.

OI-D DENIED by commercial health insurance following submission of a correct and complete claim, **or** payment was applied towards the coinsurance and deductible. Do **not** use this code unless the claim was actually billed to the health insurer.

OI-Y YES, the recipient has commercial health insurance, but it was not billed for reasons including, but not limited to:

- √ The recipient denied coverage or will not cooperate.
- √ The provider knows the service in question is not covered by the carrier.
- √ The recipient's health insurance failed to respond to initial and follow-up claims.
- √ Benefits are not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, **if applicable**:

Code Description

OI-P PAID by HMO. The amount paid is indicated on the claim.

OI-H HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the commercial HMO denied payment because an otherwise covered service was not provided by a designated network provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Appendix 16 (Continued)

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- The *non-physician* provider's Wisconsin Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes may be used when appropriate:

Code	Description
------	-------------

M-1	Medicare benefits exhausted. This code may be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:
------------	--

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

M-5	Provider is not Medicare certified. This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in these two instances only:
------------	---

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:
------------	--

Appendix 16 (Continued)

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 Noncovered Medicare service. This code may be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

Enter the referring or prescribing physician's name and his or her six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the Medicaid provider number or license number of the referring provider. Speech and hearing clinics are required to complete this element. Audiologists and hearing instrument specialists should refer to Appendix 2 of this handbook to determine whether they are required to complete this element.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Appendix 16 (Continued)

Element 19 — Reserved for Local Use

If you bill an unlisted (or not otherwise specified) procedure code, you must describe the procedure. If Element 19 does not provide enough space for the procedure description, or if you are billing multiple unlisted procedure codes, you must attach documentation to the claim describing the procedure(s). In this instance, indicate “See Attachment” in Element 19. Do not bill unlisted procedure codes through electronic billing. Unlisted procedure codes are required to be submitted through paper claims submission.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology (“E”) and manifestation (“M”) codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved PA request. Services authorized under multiple PAs must be submitted on separate claim forms with their respective PA numbers.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the “From” field.
- When billing for a range of dates for the rental of a hearing instrument, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the “From” field, and the last day of rental in the “To” field in MM/DD/YY or MM/DD/YYYY format.

It is allowable to enter on one line a range of dates for the rental of a hearing instrument if:

- Indicating only the actual days that the item was rented.
- Indicating only dates from a single month.

When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the “From” field, and subsequent DOS in the “TO” field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.

Appendix 16 (Continued)

- The charge for all procedures is identical. (Enter the total charge per detail line in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck indicator.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 4 for allowable POS codes.

Element 24C — Type of Service

Enter the appropriate Medicaid single-digit type of service (TOS) code for each service. Refer to Appendix 4 for allowable TOS codes.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Claims received without an appropriate code are denied by Wisconsin Medicaid. Refer to Appendices 1, 2, and 3 of this handbook for Wisconsin Medicaid-allowable CPT and HCPCS codes for hearing services.

Modifiers

Enter the appropriate two-character modifier in the “Modifier” column of Element 24D. Please note that Wisconsin Medicaid has *not* adopted all CPT, HCPCS, or Medicare modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — \$ Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

For a hearing aid rental service, enter the total number of days the item was rented. This must coincide with the date range indicated. For hearing aid batteries, enter the number of batteries.

Element 24H — EPSDT/Family Planning

Enter an “H” for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24I — EMG

Enter an “E” for *each* procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

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Appendix 16 (Continued)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider *for each procedure*, if the billing provider indicated in Element 33 belongs to a clinic or group.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.

Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.) Do *not* enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered

If services were provided to a recipient in a nursing home (POS "7" or "8"), indicate the nursing home's eight-digit Wisconsin Medicaid provider number.

Element 33 — Provider's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

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Appendix 17

Sample CMS 1500 Claim Form for Hearing Instrument Specialist Services

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 609 Willow					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY Anytown		STATE WI			CITY		STATE					
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX)XXX-XXXX			EMPLOYED <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>							
c. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE							
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					SIGNED _____							
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Prescribing					17a. I.D. NUMBER OF REFERRING PHYSICIAN X12345							
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. L 389.10					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
2. _____ 3. _____ 4. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE					23. PRIOR AUTHORIZATION NUMBER 1234567							
1 02 27 02		3 P		V5030		1		\$XXX XX		1.0		
2 02 27 02		3 P		V5241		1		\$XXX XX		1.0		
3												
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ XXX XX		30. BALANCE DUE \$ XXX XX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MM/DD/YY SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# _____ GRP# _____				

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Appendix 18

Sample CMS 1500 Claim Form for Audiology Services

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER 1234567890							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM/DD/YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 609 Willow					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY Anytown			STATE WI		CITY			STATE				
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) O-I-P					10. IS PATIENT'S CONDITION RELATED TO:							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO							
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____							
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Prescribing					17a. I.D. NUMBER OF REFERRING PHYSICIAN X12345							
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V53.2					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
2. _____					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
3. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
4. _____					23. PRIOR AUTHORIZATION NUMBER							
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 06 02		3	1	92534		1	\$XX XX	1.0			12345678	
2												
3												
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$ XX XX		30. BALANCE DUE \$ XX XX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MM/DD/YY SIGNED _____ DATE _____			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Group Billing 1 W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321					

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Appendix 19

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 be aware of the following:

- 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 the Prior Authorization section of the All-Provider Handbook.
- Faxed PA requests must be received by 1:00 p.m., otherwise they will be considered as received on the following business day. Faxed PA requests received on Saturday, Sunday, or holidays will be processed on the next business day.
- After faxing a PA request, providers should not send the original paperwork, such as the carbon Prior Authorization Request Form (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.
- 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.
- 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.
- When faxing information to Wisconsin Medicaid, providers should not reduce the size of the PA/RF 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 photocopies of the original PA request and attachments are 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.
- Refaxing a PA request before the previous PA request has been returned will create duplicate PA requests and may result in delays.
- 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 the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

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Glossary of Common Terms

ALD

Assistive listening device. A personal communication unit for sound amplification. A hearing aid is an example of an ALD.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or “crowding out” private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients’ health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), the CMS administers Medicare, Medicaid, related quality assurance programs and other programs. Formerly known as the Health Care Financing Administration (HCFA).

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state’s Medicaid plan. The state’s Medicaid plan is a comprehensive description of the state’s Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Department of Health and Family Services. The Wisconsin DHFS administers the Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and

community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid’s Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid’s Provider Services (telephone correspondents).
- Wisconsin Medicaid’s Direct Information Access Line with Updates for Providers (Dial-Up).

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Experimental services

According to HFS 107.035(1), Wis. Admin. Code, a service that is experimental in nature is a service, procedure, or treatment provided by a particular provider which the department has determined under HFS 107.035(2), Wis. Admin. Code, not be a proven and effective treatment for the condition for which it is intended or used.

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Wisconsin Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03 (96m), a Medicaid service that is:

- (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 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 s. 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.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A single-digit code that identifies where the service was performed.

TOS

Type of service. A single-digit code that identifies the general category of a procedure code.

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