ATTACHMENT 8
Prior Authorization Request Form (PA/RF) Completion Instructions for physical therapy, occupational therapy, and speech and language pathology services

(For prior authorization requests submitted after HIPAA implementation)

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant 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 Attachment (PA/TA), Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), or Prior Authorization/Spell of Illness Attachment (PA/SOIA), as applicable, 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

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

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

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 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

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

Element 3 — Processing Type

Enter the appropriate three-digit processing type from the list below. The processing type is a three-digit code used to identify the category of service requested. Use processing type "999" (Other) only if the requested category of service is not found in the list below. Prior authorization and spell of illness (SOI) requests will be returned without adjudication if no processing type is indicated.

111 — Physical Therapy (PT)
112 — Occupational Therapy (OT)
113 — Speech and Language Pathology (SLP)
114 — SOI for PT
115 — SOI for OT
116 — SOI for SLP
160 — Birth to 3 (B-3) for PT
161 — B-3 for OT
162 — B-3 for SLP
999 — Other (use only if the requested category or service is not listed above)

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid 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 6 — Date of Birth — Recipient

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

Element 7 — Address — Recipient

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 8 — Name — Recipient

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 9 — Sex — Recipient

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

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

Element 11 — Start Date — SOI

Do not complete this element unless requesting an SOI. Enter the date of onset for the SOI in MM/DD/YY format.

Element 12 — First Date of Treatment — SOI

Do not complete this element unless requesting an SOI. Enter the date of the first treatment for the SOI in MM/DD/YY format.

Element 13 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable. If requesting an SOI, leave this element blank.

Element 14 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format if a specific start date is requested. If requesting an SOI, leave this element blank.

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the provider who will be performing the service, *only* if this number is different from the billing provider number listed in Element 4. 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 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure requested. If requesting a B-3 service, leave this element blank.

Element 17 — Modifiers
Enter the "GP" modifier for PT services and the "GO" modifier for OT services. No modifier is needed for SLP services. Do not enter the "TF" modifier or the "TL" modifier.

Element 18 — POS
Enter the appropriate place of service (POS) code designating where the requested service/procedure would be provided/performed. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for PT, OT, and SLP services.

Element 19 — Description of Service
Enter the written description corresponding to the appropriate procedure code for each service/procedure requested. If requesting a B-3 service, enter "Birth to 3" and the therapy discipline as the description (e.g., "Birth to 3 occupational therapy services" for OT services).

Element 20 — QR
Enter the appropriate quantity requested for each procedure code listed. If requesting an SOI or a B-3 service, leave this element blank.

Element 21 — Charge
Enter the usual and customary charge for each procedure code listed. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element. If requesting an SOI or a B-3 service, leave this element blank.

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 22 — Total Charges
Enter the anticipated total charge for this request. If requesting an SOI or a B-3 service, leave this element blank.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting/performing this service/procedure must appear in this element.

Element 24 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

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