

# **Skilled Nursing Facility Authorizations for SSI, Partnership, and Medicare Dual Advantage**

# Agenda

- Submitting a new prior authorization request
- Authorization notification process
- What to expect from My Choice Wisconsin
- We are here to help

# Submitting a New Prior Authorization Request



## Important Notice:

Effective February 1, 2020 all Family Care services require authorization through the Member's Care Team.

If you require assistance in connecting with the Member's Care Team, contact the Customer Service Center at 1-800-963-0035.



# Where Can I Find the Authorization Request Form?



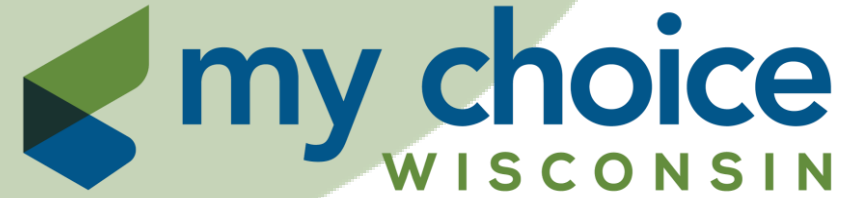
The screenshot shows the "Provider Resources" page on the My Choice Wisconsin website. At the top, there is a blue navigation bar with the text "Provider Resources" and a "Print Page" button. Below this, there is a breadcrumb trail: "Home | Provider Resources". The main content area is titled "High Quality Healthcare Provider & Long-Term Care Networks". A search bar is visible with the text "Select Document Type" and a "Go" button. A dropdown menu is open, showing "In This Section" with links for "Provider Compliance & Privacy" and "Joining Our Network". Below the search bar, there are three search results, each with a "View" button. The results are:

- Medicaid Skilled Nursing Facility (SNF) Prior Authorization Resource (October 23, 2020 | PDF (176.53 KB) | Authorizations)
- Medicare Skilled Nursing Facility (SNF) Prior Authorization Resource (October 12, 2020 | PDF (281.07 KB) | Authorizations)
- Skilled Nursing Facility (SNF) and Long Term Acute Care Prior Authorization Request Form (October 23, 2020 | PDF (195.98 KB) | Authorizations)

Blue arrows point from the search bar to the dropdown menu and from the search results to the "View" buttons.

- Go to: [www.mychoicewi.org](http://www.mychoicewi.org)
- Select Provider Resources
- Select Resource Library
- Under Search Documents, type "skilled nursing prior authorization" and select GO
- The form will be listed below. Click VIEW to open the document

# Completing the Prior Authorization Request Form



## Skilled Nursing Facility and Long Term Acute Care Prior Authorization Request

Family Care services require authorization through the member's care team. Do not use this form for authorization. If you require assistance connecting with the member's care team, contact the My Choice Wisconsin Customer Service Center at 1-800-963-0035.

For other programs, please provide the following clinical information to support medical necessity of all requests and fill form completely.

- H&P
- Discharge Summary
- Therapy Notes
- MD Progress Notes
- Labs/Radiology Studies
- Supporting Nursing Notes

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:
Facility Name:		Tax ID:
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:	Phone Number:	Fax:
Facility Medical Records Dept. Phone Number:		Fax:

Type of Request:  Elective  Urgent  Retrospective (only within 14 business days from urgent/emergent admission)

Date of admission: / /

Admission ICD10 Code:

# Clinical Documentation to Support the Request



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Facility Medical Records Dept. Phone Number:		Fax:

Type of Request:  Elective  Urgent  Retrospective (only within 14 business days from urgent/emergent admission)

Date of admission: / /

Admission ICD10 Code:

Submit relevant clinical documentation with the request to assure prompt determination and notification.



# Completing the Prior Authorization Request Form




Please fill out the fillable form completely. Information can be typed on the form or printed out and handwritten.

Member demographic information is important to assure we can match the Member in our system.

Requesting provider information helps us identify who we can follow up with should we have questions.





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Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:

Facility Name:		Tax ID:
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:	Phone Number:	Fax:
Facility Medical Records Dept. Phone Number:		Fax:

Type of Request:  Elective     Urgent     Retrospective (only within 14 business days from urgent/emergent admission)

Date of admission:    /    /

Admission ICD-9 Code: \_\_\_\_\_





# Type of Request



## Elective

A planned admission

## Urgent

A non-emergency admission that is neither life threatening nor elective but requires immediate attention for optimal outcome

## Retrospective

The request will be received by My Choice Wisconsin after service was initiated but within 14 calendar days of the start of services

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:
Facility Name:	Tax ID:	
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:		Phone Number: Fax:
Facility Medical Records Dept. Phone Number:		Fax:

Type of Request:  Elective     Urgent     Retrospective (only within 14 business days from urgent/emergent admission)

Date of admission:	/	/	
Admitting ICD10 Code:			
Admission Type:	<input type="checkbox"/> SNF Rehabilitative - Medicare	<input type="checkbox"/> SNF Rehabilitative - Medicaid	<input type="checkbox"/> SNF - Hospice
	<input type="checkbox"/> SNF Long Term Care/Custodial	<input type="checkbox"/> LTACH	

# Admission Type



## SNF Rehabilitative – Medicare

- Rehabilitative or skilled stay requiring therapy 1-2 hours per day at least 5 days per week or requiring skilled nursing services at least daily
- Member has days remaining in the Medicare benefit period
- My Choice Wisconsin DOES NOT require a 3-day qualifying stay

## SNF Rehabilitative – Medicaid

- Rehabilitative or skilled stay requiring therapy 1-2 hours per day at least 5 days per week or requiring skilled nursing services at least daily

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:
Facility Name:		Tax ID:
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:	Phone Number:	Fax:
Facility Medical Records Dept. Phone Number:		Fax:

Type of Request:  Elective  Urgent  Retrospective (only within 14 business days from urgent/emergent admission)

Date of admission: \_\_\_\_\_

Submitting ICD10 Code: \_\_\_\_\_

Admission Type:  SNF Rehabilitative - Medicare  SNF Rehabilitative - Medicaid  SNF - Hospice  
 SNF Long Term Care/Custodial  LTACH

# Admission Type



## SNF – Hospice

- Skilled Nursing Home stay for Member's enrolled in Hospice

## SNF Long Term Care/Custodial

- Skilled Nursing Home stay that primarily consists of non-medical care that can be reasonably and safely provided by non-licensed caregivers
- Custodial stays may be needed when the members' needs cannot be met at a lower level of care

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:
Facility Name:		Tax ID:
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:	Phone Number:	Fax:
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Type of Request:  Elective     Urgent     Retrospective (only within 14 business days from urgent/emergent admission)

Date of admission:    /    /
Admitting ICD10 Code:
Admission Type: <input type="checkbox"/> SNF Rehabilitative - Medicare <input type="checkbox"/> SNF Rehabilitative - Medicaid <input type="checkbox"/> SNF - Hospice
<input type="checkbox"/> SNF Long Term Care/Custodial <input type="checkbox"/> LTACH

# Authorization Notification Process



Authorization numbers will begin with "IP". You will no longer receive authorizations that start with "SR".

Example: **IP000xxxxxxx**

## Authorization Notification Letters created after 10/1/19

- An Authorization Notification letter will be issued promptly following receipt of pertinent clinical information
- The notification will be faxed to the provider contact listed on the Prior Authorization Request Form
- Authorization Notification letters will be mailed if no fax number is listed
- At this time "IP" authorizations are not viewable on the My Choice Wisconsin Authorization Portal

# Types of Notifications



\*Notification letter design and layout vary by program

## Approval Notification

Member: [REDACTED]  
Medicaid ID#: [REDACTED]  
Member Number: [REDACTED]  
Authorization #: IP000-[REDACTED]

Thank you for your request to complete a service authorization.

After a review of the information provided to us, we have certified the following services:

Procedure Code	Procedure Description	Service Provider	Approved Dates of Service	Approved Units
			08/16/2019-08/23/2019	7 Days

## Denial Notification

**Important:** This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

**Notice of Denial of Payment**

Date: 05/21/2018  
Name: [REDACTED]  
[REDACTED]

Member number: [REDACTED]  
Date of Birth: [REDACTED]  
Request Date: [REDACTED]

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**Your request was denied**



# What to Expect From My Choice Wisconsin

## Quality Care Management

- My Choice Wisconsin RN and Care Manager collaboration to support safe and effective discharges to the next level of care

## Prompt Determinations

- Pre-certification for Hospital to Skilled Nursing Facility transfers
- Determination and notification will occur within 1 business day following receipt of pertinent clinical documentation

# What to Expect From My Choice Wisconsin

## Ongoing Concurrent Review

- Rehabilitative Medicare and Medicare stays are authorized for 1-2 weeks at a time
- Custodial Stays are reviewed every 6 months or more frequently if the Member's condition changes

## Single Point of Entry for Authorization-Related Questions

- The Customer Service Team is available at 1-800-963-0035
- This team will answer your questions or connect you with someone who can

# We are Here to Help!



Visit [www.mychoicewi.org/providers/authorizations/](http://www.mychoicewi.org/providers/authorizations/) to get prior authorization request forms as well as other authorizations resources.

If you have any questions, please call us promptly at 1-800-963-0035.

## Important Contacts

<b>Customer Service Center</b>	<b>Prior Authorization Fax</b>
<b>800-963-0035</b>	<b>608-210-4050</b>