My Choice Wisconsin® Partnership and Dual Advantage
Pre-Service Review Guide
Effective: 01/01/2025

FOR DUAL ELIGIBLE MEMBERS, SERVICES ARE ALSO SUBJECT TO STATE MEDICAID PA REQUIREMENTS.

Refer to My Choice Wisconsin Provider Website/Prior Authorization Look-up Tool for specific codes that require Authorization

Only covered services are eligible for reimbursement.

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

The following services may require Prior Authorization:

- **Advanced Imaging and Special Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Partial hospitalization (require notification and concurrent review), Intensive Outpatient above 16 units
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology**
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing**
- **Healthcare Administered Drugs**
  - Refer to the PA Look Up Tool to determine codes requiring prior authorization
- **Hearing Aids**
  - For Partnership Medicaid only: please reference code information on PA lookup tool
  - For Partnership Dual eligible and MCW Dual Advantage: Coverage underMedicare benefit is through Nations Benefits at 877-208-9243
- **Home Healthcare Services (including home-based PT/OT/ST):** Prior authorization required after the first three 30-day episodes of care per calendar year.
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS):** Not a Medicare covered benefit*. **(*Per State benefit for dual benefit members.)**
- **Miscellaneous & Unlisted Codes:** My Choice requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Non-Par Providers: With the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval. Exceptions include:**
  - Local Health Department (LHD) services;
  - Hospital Emergency services;
  - Evaluation and Management services associated with inpatient, ER, and observation stays, or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61);
  - Dialysis when temporarily absent from service area;
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.-
  - Radiologists, anesthesiologists, and pathologists professional services when billed in POS 19, 21, 22, 23, 24, 51, 52;
- **Occupational, Physical, & Speech Therapy**: PA required after 12 visits of each discipline per calendar year
- **Oncology**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).

Important Information for My Choice Wisconsin Healthcare Medicare Providers

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT, Lab, or X-ray report/results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting and servicing provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax, or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- My Choice Wisconsin has a full-time Medical Director available to discuss medical necessity decisions for Inpatient Hospitalizations with the requesting physician. Please contact our Customer Service center at (800) 963-0035 to set up a time to discuss the case. Peer to Peer reviews must be requested within 5 business days from the date of discharge or date of denial whichever is later.

A retroactive authorization will be accepted if it meets the following requirements:

- **Request is received by My Choice Wisconsin within 14 calendar days of the start of the provision of services**
- **Request precedes a bill for services**
- **Request includes justification for beginning the service prior to receiving authorization:**
  - **The member was not able to tell the provider about their insurance coverage prior to rendering services, or**
  - **The provider verified different insurance coverage prior to rendering services**

Important My Choice Wisconsin Healthcare Medicare Contact Information

(Service hours 8am-4:30 pm local M-F, unless otherwise specified)

Outpatient Prior Authorizations including Behavioral Health Authorizations: Phone: (800) 963-0035 Fax: (608) 210-4050	**Inpatient Authorizations** Phone: (800) 963-0035 Fax: (608) 210-4050 Peer to Peer: (800) 963-0035
Retail Pharmacy Authorizations Phone: (800) 665-3086 Fax: (866) 290-1309	**Dental:Skygen** Phone: (800) 508-4890 Website: https://pwp.skygenusasystems.com/PWP/Landing
Part B drugs/Physician Administered Meds: Phone: (800) 963-0035 Fax: (608) 210-4050	**Vision (VSP):** Phone: (855) 492-9028 Website: https://www.vspproviderhub.com/contact.html
Provider Contact Center Phone: (855) 326-5059 Fax: (877) 556-5863 Email: MHWIProviderNetworkManagement@MolinaHealthcare.com	**Member Customer Service, Benefits/Eligibility:** Phone: (800) 963-0035/ TTY/TDD 711

Important My Choice Wisconsin Healthcare Medicare Contact Information

Claims: Cognizant Phone: (855) 878-6699 **Claims: WPS** Phone: (800) 223-6016 Fax: (608) 327-6332	**Transplant Authorizations:** Phone: (800) 963-0035 Fax: (608) 210-4050
Radiology Authorizations Phone: (800) 963-0035 Fax: (608) 210-4050	**24 Hour Nurse Advice Line (7 days/week)** Phone: (800)963-0035/TTY: 711

Providers may utilize My Choice Healthcare's Website at: https://mychoicewi.org

Available features include:

- Prior Authorization Look Up tool
- Provider Directory
- Provider Trainings
- Download Frequently used forms
- Molina Clinical Policies
- MCG

My Choice Wisconsin– Pre Service Request Form: Fax to 608-210-4050

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Medicare**		**Date of Request:**
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency (**Required**):_____ ☐ Emergent Inpatient Admission ☐ EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Laboratory Services	☐ Physical Therapy
☐ Inpatient or SNF Hospice	☐ CGM/supplies	☐ Non Par	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ DME/DMS	☐ Occupational Therapy	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Genetic Testing	☐ Outpatient Procedures	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility Medicare A	☐ Home Health	☐ Pain Management	☐
☐ Skilled Nursing Facility Medicaid	☐ Hospice	☐ Palliative Care	☐ Wound Care/Hyperbaric
☐ Skilled Nursing Facility Custodial	☐ Imaging/Special Tests	☐ Pharmacy/Infusion Therapy	☐ Other: _____
☐ Other Inpatient:_____			

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

DATES OF SERVICE START	DATES OF SERVICE STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**FAX**:	**Email**:	
Address:	**City:**	**State:**	**Zip:**
PCP Name:	**PCP Phone**:		
Office Contact Name:	**Office Contact Phone**:		

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):			
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par** ☐**COC**
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

My Choice Wisconsin– BH Pre Service Request Form: Fax to 608-210-4050

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Medicare**	☐	**Date of Request:**
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____ ☐ Emergent Inpatient Admission			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐Involuntary ☐Voluntary ☐ Inpatient Detoxification ☐Involuntary ☐Voluntary If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: **Description:**

DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**FAX**:	**Email**:	
Address:	**City:**	**State:**	**Zip:**
PCP Name:	**PCP Phone**:		
Office Contact Name:	**Office Contact Phone**:		

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):			
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par** ☐**COC**
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.