Prior Authorization of Procedures

PRIOR AUTHORIZATION DEFINITION

Prior authorization is the process of obtaining Physicians Plus authorization prior to the member receiving services. The purpose of the prior authorization function is for Physicians Plus to determine member eligibility, benefit coverage, medical necessity, location and appropriateness of services.

Verbal or written requests do not constitute prior authorization without approval. Approval is subject to all other policy limits and provisions.
Prior Authorization of Procedures

SERVICES REQUIRING PRIOR AUTHORIZATION

The following services require prior authorization from Physicians Plus before rendering services:

- Acupuncture
- Artificial Disc Replacement Surgery
- Autism, Intensive Therapy Services.
  - To obtain Prior Authorization and/or find a Participating Provider, contact UW Behavioral Health at (608) 417-4709 or (800) 683-2300.
- Bariatric Outpatient Surgery
- Bone Anchored Hearing Aid (BAHA)
- Cosmetic Procedures (Potential)
  - Including but not limited to: Benign Skin Lesions, Blepharoplasty, Botox Injections, Canthoplasty, Male Gynecomastia, Microtia, Reduction Mammoplasty, Rhinoplasty, Skin Tag Removal, Varicosity Procedures
- CT Endoscopy (Virtual CT)
- Deep Brain Stimulation (DBS)
- Durable Medical Equipment (DME)
  - All DME purchases over $750
  - All DME rentals over $750 per month
  - All CPAP machine purchases
  - All DME Replacement Items
  - Continuous Glucose Monitoring (CGM) Transmitter System
  - Mechanical Stretching Devices (Contracture/Joint Stiffness)
  - Traction for Spinal Pain (Home Use)
  - Please refer to section F6 for additional information regarding coverage of DME.
- Electroconvulsive therapy (ECT)
- Functional Electrical Stimulation
- Genetic testing & Molecular Pathology
- Home care services, supplies and therapies
- Infusion Medications (See online Pharmacy Medication Pre-Authorization list)
Prior Authorization of Procedures

- Inpatient services at:
  - Acute care facility
  - Hospice facility
  - Long term acute care facility
  - Rehabilitation facility
  - Skilled nursing facility (including therapy)
  - Subacute facility
- Intrathecal Pump Implantation
- Intratympanic Steroid Injection
- Laser Treatments for Psoriasis
- Lumbar Discography
- Non-emergent Patient Transportation
- Non-participating providers: ALL services
- Oral / Orthognathic Surgery
- Orthopedic and Neurosurgery Referrals (State of Wisconsin Employees only)
- Prophylactic Ovary/Breast Removal
- Prostate Cryosurgery or Vaccine
- Prosthetics: All Purchases
- Radiofrequency Thermal Ablation for Barrett’s Esophagus
- Spinal Cord Stimulators
- Stem Cell Storage (Non-Transplant)
- Stereotactic Radiosurgery
- Temporomandibular – OP Surgery & Devices
- Transplant Evaluations & Services
- Vagus Nerve Stimulation
- Virtual Colonoscopy
- Note: For members with a Medicare Supplement Policy, Prior Authorization is only required for Nursing Home stays.
Completing the Prior Authorization Form

When the physician determines the patient is in need of medical or specialty care that requires prior authorization, the physician will complete a prior authorization form. The Prior Authorization Form has five sections that must be completed in its entirety. Prior Authorization requests may be submitted to Physicians Plus via telephone, mail, PlusLink or by fax.

Patient Information
Please complete this section as thoroughly as possible, including the patient's name, address, phone number, member number, and insurance status.

Primary Care Provider
Please supply the provider name, address, and phone number.

Services Provided By
On the form, please supply the provider name, address, phone number and specialty.

Appointment Information
Describe the requested services including duration dates and total number of visits. The duration of the Prior Authorization must not exceed 12 months.

Reason for Request
Check Prior Authorization for services referred to a non-participating provider and/or for services requiring prior authorization.

Thoroughly complete the Diagnosis Code, narrative description, and the reason for Prior Authorization in the narrative section. Check the appropriate box to include or exclude other services. Please include the medical records that support the request, to significantly reduce the processing time.

If the request is for a non-participating provider, the following must be listed on the Prior Authorization form:
- the specific requested services
- the specific physician for the referral
- the reason why the requested service cannot be provided by a participating provider
Prior Authorization of Procedures Section

Submitting the Prior Authorization Form

The Prior Authorization form should be forwarded to the Care Management Department at Physicians Plus. Our Care Management Department will review the request and either approve or deny the requested services. Care Management will forward a determination to all appropriate parties.

Physicians Plus’ Medical Director/Physician Reviewer is available to discuss any denial decisions. If the treating physician would like to discuss the case with a Physician Reviewer, please call Care Management at (608) 282-8900 or 1-800-545-5015 to schedule a time for a Peer-to-Peer review.

The Prior Authorization form can be completed and submitted electronically through PlusLink.

Mail the Prior Authorization form to:

Physicians Plus Insurance Corporation
Care Management Department
2650 Novation Parkway
Madison, WI 53713

If services that require Prior Authorization need to be provided in less than seven days, Prior Authorization may be obtained via telephone or fax by contacting our Care Management Department:

Phone# (608) 282-8900 or 1-800-545-5015
Fax # (608) 327-0322

Obtaining Additional Prior Authorization Forms


If you have questions regarding the prior authorization process or to obtain additional copies of the Prior Authorization Form, you may contact the Provider Services Department at (608) 282-8900 or 1-800-545-5015.
Prior Authorization of Procedures

PROVIDER RESPONSIBILITY

Prompt and accurate payment of claims is in everyone’s best interest and is integral to Physicians Plus’ Code of Ethics and corporate goals. However, there are some services that may be denied provider responsibility. Physicians Plus Providers must not seek reimbursement from Physicians Plus members for services that deny provider responsibility; Physicians Plus members must be held harmless for those services. Claims that deny provider responsibility can be appealed by following the guidelines in Section K2.1 of this manual.

Here are some examples of provider responsibility denials: timely filing, authorization required but not obtained, code not on fee schedule,

Here are some examples of services for which Physicians Plus members may be billed: copays, deductibles, co-insurance, benefit exclusions and member not eligible at time of service.

The remittance advice you receive from Physicians Plus will indicate the status of a claim, whether it is paid, denied provider responsibility, or denied member responsibility. If you have any questions regarding the status of a claim, contact our Provider Services Department at (800) 545-5015.
DURABLE MEDICAL EQUIPMENT (DME)

Definition
Physicians Plus defines Durable Medical Equipment (DME) as an item which can withstand repeated use and which, as determined by Physicians Plus, meets all of the following:

A) Primarily used to serve a medical purpose with respect to an illness or injury;
B) Generally not useful to a person in the absence of an illness of injury;
C) Appropriate for use in the member’s home, but may not be limited to home use; and
D) Prescribed by a physician.

Authorization Requirements
- All DME purchases over $750
- All DME rentals over $750 per month
- All CPAP machine purchases
- All DME replacement items
- Continuous Glucose Monitoring (CGM) Transmitter
- Mechanical Stretching Devices (Contracture/Joint Stiffness)
- Traction for Spinal Pain (Home Use)

Non covered
DME items require prior authorization if the cost is $750 or more. However that does not guarantee payment by Physicians Plus. Some DME items are considered over-the-counter items or are otherwise benefit exclusions. Other DME items have quantity limitations and are not payable by Physicians Plus once the member has received the maximum number of items for that benefit year.

In addition, all prosthetics require prior authorization regardless of the cost.

Medical necessity guidelines will apply for any DME or prosthetic purchased.

All DME purchases and rentals are subject to member co-insurance amounts and deductibles.