

## 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.

## SERVICES REQUIRING PRIOR AUTHORIZATION

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

- Acupuncture
- Autism, Intensive Therapy Services.
  - To obtain Prior Authorization and/or find a Participating Provider, contact UW Behavioral Health at (608) 233-3575 or (800) 683-2300.

***The following Prior Authorization requirement for Durable Medical Equipment will be in effect until December 31, 2011***

- Durable Medical Equipment/prosthetics/supplies: All purchases over \$5,000.00 require prior authorization.

***The following Prior Authorization requirement for Durable Medical Equipment (DME) and supplies will be in effect January 1, 2012***

- Durable Medical Equipment and Supplies:
  - All purchases over \$750
  - All rentals over \$750 per month
  - All CPAP machine purchases and rentals

*Please refer to section F6 for additional information regarding coverage of DME.*

- Electroconvulsive therapy (ECT)
- Genetic testing
- Home care services, supplies and therapies
- Hospice care
- Inpatient services at:
  - Acute care facility
  - Hospice facility
  - Long term acute care facility
  - Rehabilitation facility

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- Skilled nursing facility (including therapy)
- Subacute facility
- Non-emergent ambulance transportation
- Non-participating providers: ALL services
- Outpatient procedures/surgery/services that may be considered cosmetic, including but not limited to:
  - Blepharoplasty
  - Botox injections
  - Canthoplasty
  - Reduction mammoplasty
  - Septo-rhinoplasty
  - Skin Tag removal
- Prosthetics, Limb: All purchases
- Rehabilitation:
  - Day / Neurotrauma
- Transplants
- Note: For members with a Medicare Supplement Policy, Prior Authorization is required for Nursing Home stays and for visits to non-participating providers only.

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**PRIOR AUTHORIZATION FORM****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 and sign a prior authorization form. The Prior Authorization Form has five sections that the physician must complete in its entirety. Prior Authorization requests may be forwarded to Physicians Plus by telephone, mail, Go-To, 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. Signature of the referring provider and date signed is required.

## Services Provided By

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

## Appointment Information

Describe the services being requested 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. Having the necessary information significantly reduces processing time.**

If the request is for a **non-participating provider**, the following must be listed on the Prior Authorization form:

- the specific services being requested
- the specific physician to whom the patient is being referred
- **the reason why the requested service cannot be provided by a participating provider**

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### **Submitting the Prior Authorization Form**

The Prior Authorization form should be forwarded to the Health Services Department at Physicians Plus. Our Health Services Department will review the request and either approve or deny the requested services. Health Services 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 Health Services at (608) 282-8900 or 1-800-545-5015.

The Prior Authorization form can be completed and submitted electronically through GO-TO.

#### **Mail the Prior Authorization form to:**

Physicians Plus Insurance Corporation  
Health Services 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 Health Services Department:

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

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### **Obtaining Additional Prior Authorization Forms**

Copies of the Standard Prior Authorization Form can be downloaded and printed from the “Provider Manual and Forms” section of our website [www.pplusic.com](http://www.pplusic.com).

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.

## **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 members are held harmless for services that deny provider responsibility. 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, and duplicate claims.

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 or 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**

***The following Prior Authorization requirement for DME and supplies will be in effect until December 31, 2011***

- All purchases over \$5,000.00 require prior authorization

***The following Prior Authorization requirement for DME and supplies will be in effect January 1, 2012***

- All purchases over \$750
- All rentals over \$750 per month
- All CPAP machine purchases and rentals

### **Non covered**

DME items does require prior authorization if the cost is \$750,00 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 limb 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.