ForwardHealth
Wisconsin serving you

Update
July 2008

No. 2008-113

Affected Programs: BadgerCare Plus, Medicaid
To: Home Health Agencies, Personal Care Agencies, Nurses in Independent Practice, HMOs and Other Managed Care Programs

Changes to Prior Authorization for Home Health Services, Including Private Duty Nursing and Private Duty Nursing to Ventilator-Dependent Members

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for home health services, including private duty nursing and private duty nursing to ventilator-dependent members, effective October 2008, with the implementation of the ForwardHealth interChange system. These changes include the following:

- Establishing deadlines for providers to respond to returned PA requests and PA amendment requests.
- Revising all PA forms. The following PA forms will be available to download and print from the Web at *dhs.wisconsin.gov/ForwardHealth/*:
  - ✓ Prior Authorization Request Form (PA/RF), F-11018 (10/08).
  - ✓ Prior Authorization Amendment Request, F-11042 (10/08).
  - ✓ Prior Authorization/Home Care Attachment (PA/HCA), F-11096 (10/08).
  - ✓ Prior Authorization/Home Health Therapy Attachment (PA/HHTA), F-11044 (10/08).
  - ✓ Private Duty Nursing Prior Authorization Acknowledgment, F-11041 (10/08).

Providers may also order copies from Provider Services.

The changes were made to do the following:

- Provide efficiencies for both providers and ForwardHealth.
- Accommodate changes required for full National Provider Identifier implementation.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

A separate *Update* will give providers a calendar of additional important dates related to implementation including when to begin submitting the revised PA forms.

Information in this *Update* applies to providers who provide services for BadgerCare Plus Standard Plan and Wisconsin Medicaid members.

Changes to Prior Authorization with the Implementation of ForwardHealth interChange

In October 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process

enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA forms and procedures that are detailed in this *Update*. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements). The changes were made to:

- Provide efficiencies for both providers and ForwardHealth. Providers will be able to submit PA requests and receive decisions and requests for additional information via the ForwardHealth Portal.
- Accommodate changes required for full National Provider Identifier (NPI) implementation. Prior authorization forms were revised to include elements for providers to indicate NPI and taxonomy information.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

Note: Specific implementation dates will be published in a separate *Update*. Use of information presented in this *Update* prior to implementation may result in returned PA requests.

Information in this *Update* applies to providers who provide services for BadgerCare Plus Standard Plan and Wisconsin Medicaid members.

Submitting Prior Authorization Requests

Using the ForwardHealth Portal, providers will be able to submit PA requests for *all* services requiring PA. In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Mail to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  6406 Bridge Rd
  Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

Prior Authorization Numbers

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 1 of this *Update* for information about interpreting PA numbers.

Changes to Prior Authorization Forms

With the implementation of ForwardHealth interChange, providers submitting a paper PA request for home health services will be required to use the revised PA/RF. Refer to Attachments 2 and 3 for completion instructions and a copy of the PA/RF, for providers to photocopy. Attachments 4 and 5 are sample PA/RFs for home health services.

Note: If ForwardHealth receives a PA request on a previous version of the PA/RF, a letter will be sent to the provider stating that the provider is required to submit a new PA request using the proper forms. This may result in a later grant date if the PA request is approved.

Revisions to the Prior Authorization Request Form and Instructions

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).
- Checkboxes are added for HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- The term "rendering provider" replaces "performing provider" to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider's name and address fields, providers are now required to include the ZIP+4 code (Element 4) to accommodate NPI implementation.

Prior Authorization Attachments

With the implementation of ForwardHealth interChange, providers submitting a paper PA request for home health services will be required to use the revised Prior Authorization/Home Care Attachment (PA/HCA), F-11096 (10/08), the Prior Authorization/Home Health Therapy Attachment (PA/HHTA), F-11044 (10/08), and the Private Duty Nursing Prior Authorization Acknowledgment, F-11041 (10/08). While the basic information requested on the forms has not changed, the format of the form has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests. Refer to Attachment 6 for a copy of the completion instructions for the PA/HCA. Attachment 7 is a copy of the PA/HCA for providers to photocopy. Refer to Attachment 8 for a copy of the completion instructions for the PA/HHTA. Attachment 9 is a copy of the PA/HHTA for providers to photocopy. Attachment 10 is a copy of the Private Duty Nursing Prior Authorization Acknowledgment form for providers to photocopy.

Obtaining Prior Authorization Request Forms and Attachments

The PA/RF, PA/HCA, PA/HHTA, and the Private Duty Nursing Prior Authorization Acknowledgement form are available in fillable PDF or fillable Microsoft® Word from the Forms page at *dhs.wisconsin.gov/ForwardHealth/* prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically.

To request a paper copy of the PA/RF, PA/HCA, PA/HHTA, or Private Duty Nursing Prior Authorization Acknowledgement for home health services for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the form (if applicable) and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Prior Authorization Decisions

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved as requested.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status in WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

New Amendment Process

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information.

Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 11. Attachment 12 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the

Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Valid Diagnosis Codes Required

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least

the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhs.wisconsin.gov/forwardhealth/*.

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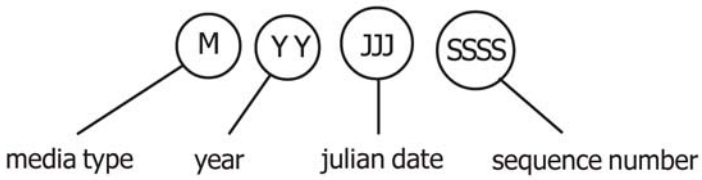
ATTACHMENT 1
Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction
Year — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

ATTACHMENT 2
Prior Authorization Request Form (PA/RF) Completion Instructions for Home Health Services, Including Private Duty Nursing and Private Duty Nursing to Ventilator-Dependent Members

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the Prior Authorization/Home Care Attachment (PA/HCA), F-11096, or the Prior Authorization/Home Health Therapy Attachment (PA/HHTA), F-11044, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
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 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck "Other Services." Enter an "X" in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter process type 120 for home health services. The process type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no process type is indicated.

Element 3 — 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 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct number.

Element 7 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 16 — Rendering Provider Number (not required)

Element 17 — Rendering Provider Taxonomy Code (not required)

Element 18 — Procedure Code
Enter the appropriate Current Procedural Terminology code or Healthcare Common Procedure Coding System procedure code for each service/procedure requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 20 — POS
Enter POS (place of service) code "12." The member's home is the only allowable POS.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate procedure code for service/procedure requested. Indicate in the description the credentials of the individual who provided the service (e.g., licensed practical nurse, registered nurse).

When requesting home health skilled nursing, home health aide, or home health therapy services, indicate the number of visits per day, multiplied by the number of days per week, multiplied by the total number of weeks being requested.

When requesting private duty nursing (PDN) services, indicate the number of hours per day, multiplied by the number of days per week, multiplied by the total number of weeks being requested.

If sharing a case with another provider, enter "shared case" and include a statement that the total number of hours of all providers will not exceed the combined total number of hours ordered on the physician's plan of care (POC). When requesting two procedure codes to be used interchangeably, include a statement that the total number of hours will not exceed the combined total number of hours ordered on the physician's POC. When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits to do (number of) continuous hours of care."

Element 22 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

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 provider *Terms of Reimbursement* issued by the Department of Health Services.

Element 24 — Total Charges
Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

ATTACHMENT 3
Prior Authorization Request Form (PA/RF)
(for photocopying)

(A copy of the "Prior Authorization Request Form [PA/RF]" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable ❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	2. Process Type	3. Telephone Number — Billing Provider
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)		5a. Billing Provider Number 5b. Billing Provider Taxonomy Code

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
9. Name — Member (Last, First, Middle Initial)	10. Gender — Member ❑ Male ❑ Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date	

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	

25. **SIGNATURE** — Requesting Provider	26. Date Signed

DT-PA049-049

ATTACHMENT 4
Sample Prior Authorization Request Form (PA/RF) for Private Duty Nursing Ventilator-Dependent Member Services

(A copy of the sample "Prior Authorization Request Form [PA/RF]" for private duty nursing ventilator-dependent member services is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**120**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
V46.11 — Ventilator		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
344.00 — Quadriplegia, unspecified	**MM/DD/CCYY**

16. Rendering Provider Number	17. Rendering Provider Taxonomy	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
		99504	**TD**				**12**	**RCS-HH/RN 12°/d, 7d/wk x 53 wks**	**4,452 hrs**	**XX,XXX.XX**
		99504	**TE**				**12**	**RCS-HH/LPN 12°/d, 7d/wk x 53 wks**	**4,452 hrs**	**XX,XXX.XX**
								Shared case with independent nurse. Total hours for all providers will not exceed total hours in plan of care.		

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**X,XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**

ATTACHMENT 5
Sample Prior Authorization Request Form (PA/RF) for Private Duty Nursing for Home Health Therapy Services

(A copy of the sample "Prior Authorization Request Form [PA/RF]" for private duty nursing for home health services is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**120**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
429.2 — Cardiovascular disease		

11. Diagnosis — Primary Code and Description	15. Requested PA Start Date
250.00 — Diabetes II	**MM/DD/CCYY**

16. Rendering Provider Number	17. Rendering Provider Taxonomy	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
		97799					**12**	**HH — physical therapy** **1 visit/day x 3 days/wk x 26 weeks**	**78 visits**	**X,XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**X,XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**

ATTACHMENT 6
Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions

(A copy of the "Prior Authorization/Home Care Attachment [PA/HCA] Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The Prior Authorization/Home Care Attachment (PA/HCA), F-11096, is a plan of care (POC) that may be completed for ForwardHealth members receiving home care services. The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Retain the original, signed PA/HCA, F-11096. Attach a copy of the PA/HCA to the Prior Authorization Request Form (PA/RF), F-11018, and submit it to ForwardHealth along with any attached additional information. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1a — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 1b — Telephone Number — Member
Enter the telephone number, including the area code, of the member. If the member's telephone number is not available, enter "N/A."

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 3 — Start of Care Date
Enter the date that covered services began for the member in MM/DD/CCYY format. The start of care date is the date of the member's first billable home care visit. This date remains the same on subsequent POC until the member is discharged.

Element 4 — Certification Period
Enter the beginning and ending dates of the member's certification period respectively in the "From" and "To" portions of this element in the MM/DD/CCYY format. The certification period identifies the period of time approved by the attending physician for the POC.

The "To" date can be *up to*, but not more than, 62 days later than the "From" date. (Medicare-certified agencies should use the timeframe of up to, but not more than, *60 days* later.) For certification periods that cover consecutive 31-day months, providers should be careful not to exceed 62 days.

Services provided on the "To" date are included in the certification period. On subsequent periods of recertification, the certification period should begin with the day directly following the date listed as the "To" date in the immediately preceding certification period.

Example:

Initial Certification Period	
"From" date	12/01/04
"To" date	01/31/05

Subsequent Recertification Period	
"From" date	02/01/05
"To" date	04/03/05

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

Element 5 — Principal Diagnosis
Enter the principal diagnosis information. Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code, diagnosis code description, and the date of onset in MM/DD/CCYY format. If the member's condition is chronic or long-term in nature, use the date of exacerbation.

Element 6 — Surgical Procedure and Other Pertinent Diagnoses
Enter the surgical procedure information, if any, that is relevant to the care rendered or the services requested. Include the appropriate ICD-9-CM diagnosis code, diagnosis code description, and the date of the surgical procedure in MM/DD/CCYY format. The month and year of the date of the surgical procedure must be included. Use "00" if the exact day of the month is unknown.

Enter all other diagnoses pertinent to the care rendered for the member. Include the appropriate narrative or ICD-9-CM diagnosis code, code description, and the date of onset in MM/DD/CCYY format. Include all conditions that coexisted at the time the POC was established or that subsequently developed. Exclude conditions that relate to an earlier episode not associated with this POC. Other pertinent diagnoses in this element may be changed to reflect changes in the member's condition.

If a relevant surgical procedure was not performed and there are no other pertinent diagnoses, enter "N/A" (do not leave the element blank).

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

Element 7 — Durable Medical Equipment
Identify the item(s) of durable medical equipment (DME) ordered by the attending physician and currently used by the member. Enter "N/A" if no known DME has been ordered.

Element 8a — Functional Limitations
Enter an "X" next to all items that describe the member's current limitations as assessed by the attending physician and the nurse or therapist. If "Other" is checked, provide further explanation in Element 8b.

Element 8b
If "Other" is checked in Element 8a, specify the other functional limitations.

Element 9a — Activities Permitted
Enter an "X" next to all activities that the attending physician permits and/or that are documented in the attending physician's orders. If "Other" is checked, provide further explanation in Element 9b.

Element 9b
If "Other" is checked in Element 9a, specify the other activities the member is permitted.

Element 10 — Medications
Enter the attending physician's orders for all of the member's medications, including the dosage, frequency, and route of administration for each. If any of the member's medications cause severe side effects or reactions that necessitate the presence of a nurse, therapist, home health aide, or personal care worker, indicate the details of these circumstances in this element.

Element 11 — Allergies
List any medications or other substances to which the member is allergic (e.g., adhesive tape, iodine, specific types of food). If the member has no known allergies, indicate "no known allergies."

Element 12 — Nutritional Requirements
Enter the attending physician's instructions for the member's diet. Include specific dietary requirements, restrictions, fluid needs, tube feedings, and total parenteral nutrition.

Element 13 — Mental Status
Enter an "X" next to the term(s) that most accurately describes the member's mental status. If "Other" is checked, provide further explanation.

Element 14 — Prognosis
Enter an "X" next to the one term that specifies the most appropriate prognosis of the member.

SECTION IV — ORDERS

Element 15 — Orders for Services and Treatments
Indicate the following as appropriate for each individual service:

- Number of member visits (e.g., home health skilled nursing, home health aide, or medication management), frequency of visits, and duration of visits ordered by the attending physician's orders (e.g., 1 visit, 3 times/week, for 9 weeks).
- Number of hours required for member visits (e.g., private duty nursing [PDN] or personal care), frequency of visits, and duration of visits ordered by the attending physician (e.g., 8 hours/day, 7 days/week, for 9 weeks).
- Duties and treatments to be performed.
- Methods for delivering care and treatments.
- Procedures to follow in the event of accidental extubation, as applicable.
- Ventilator settings and parameters, as applicable.

Services include, but are not limited to, the following:

- Home health skilled nursing.
- Home health aide.
- Private duty nursing.

Orders must include all disciplines providing services for the member and all treatments the member receives regardless of whether or not the services are billable to ForwardHealth. Orders indicated on this POC should be as detailed and specific as those ordered and written by the attending physician.

Pro re nata (PRN), or "as needed," home care visits or hours may be ordered on a member's POC only when indicating how these visits or hours will be used in a manner that is specific to the member's potential needs. Both the nature of the services provided and the number of PRN visits or hours to be permitted for each type of service *must* be specified. Open-ended, unqualified PRN visits or hours do not constitute an attending physician's orders because both the nature and frequency of the visits or hours *must* be specified.

When flexible use of PDN hours is requested, specify the date on which the flexibility period begins. The begin date specified for the use of flexible hours must be a date covered under this POC.

Nurses in independent practice (NIP) are required to include the name and license number of the registered nurse (RN) providing coordination services under this element. An NIP that is a licensed practical nurse is required to include the name and license number of the RN supervisor under this element.

Element 16 — Goals / Rehabilitation Potential / Discharge Plans
Enter the attending physician's description of the following:

- Achievable and measurable goals for the member.
- The member's ability to attain the set goals, including an estimate of the length of time required to attain the goals.
- Plans for the member's care after discharge.

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

Element 17 — Date Physician Last Saw Member
Enter the date the attending physician last saw the member in MM/DD/CCYY format. If this date cannot be determined during the home visit, enter "Unknown."

Element 18 — Dates of Last Inpatient Stay Within 12 Months
Enter the admission and discharge dates of the member's last inpatient stay within the previous 12 months, if known. Enter "N/A" if this element does not apply to the member.

Element 19 — Type of Facility for Last Inpatient Stay
Enter one of the following single-letter responses to identify the type of facility of the member's last inpatient stay, if applicable:

- A (Acute hospital).
- S (Skilled nursing facility).
- R (Rehabilitation hospital).
- I (Intermediate care facility).
- O (Other).
- U (Unknown).

This element must be completed if a surgical procedure was entered in Element 6. Enter "N/A" if this element does not apply to the member.

Element 20 — Current Information
For initial certifications, enter the clinical findings of the initial assessment visit for each discipline involved in the POC. Describe the clinical facts about the member that require home care services and include specific dates in MM/DD/CCYY format.

For recertifications, enter significant clinical findings about the member's symptoms, new orders, new treatments, and any changes in the member's condition during the past 60 days for each discipline involved in the POC. Document both progress and lack of progress for each discipline. Include specific dates in MM/DD/CCYY format.

Include any pertinent information about any of the member's inpatient stays and the purpose of contact with the physician, if applicable.

Element 21 — Home or Social Environment
Enter information that will justify the need for home care services and enhance the ForwardHealth consultant's understanding of the member's home situation (e.g., member lives with mentally disabled son who is unable to provide care or assistance to member). Include the availability of caretakers (e.g., parent's work schedule). The description may document problems that are, or will be, an impediment to the effectiveness of the member's treatment or rate of recovery.

Element 22 — Medical and / or Nonmedical Reasons Member Regularly Leaves Home
Enter the reasons that the member usually leaves home. Indicate both medical and nonmedical reasons, including frequency of occurrence of the trips (e.g., doctor appointment twice a month, barbershop once a month, school every weekday for three hours).

Element 23 — Back-up for Staffing and Medical Emergency Procedures
This element is required for all providers requesting PDN services. It is optional for all other home care providers.

Enter the back-up plan for staffing and medical emergency procedures. The following information must be included in this element:

- A plan for medical emergency, including:
  - ✓ A description of back-up personnel needed.
  - ✓ Provision for reliable, 24 hours a day, 7 days a week emergency service for repair and delivery of equipment.
  - ✓ Specification of an emergency power source.
- A plan to move the member to safety in the event of fire, flood, tornado warning or other severe weather, or any other condition that threatens the member's immediate environment.

SECTION VI — SIGNATURES

Those signing the POC are to acknowledge their responsibilities and consequences for non-compliance. Provider-created formats must contain the following statement that is included on the PA/HCA:

> *"Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws."*

Elements 24 and 25 — Signature and Date Signed — Authorized Nurse Completing Form
The RN completing this PA/HCA is required to sign and date this form. The signature certifies that the nurse has received authorization from the attending physician to begin providing services to the member. These elements must be completed on or before the certification period "From" date indicated in Element 4.

Provider-created formats must contain the following statement accompanying the authorized nurse's signature:

> *"As the nurse completing this plan of care, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this plan of care is carried out as specified."*

Element 26 — Date of Verbal Orders for Initial Certification Period
Enter the date the nurse signing in Element 24 receives verbal orders from the attending physician to start care for the initial certification period. If the nurse did not receive verbal orders, leave this element blank.

Element 27 — Date Received Physician-Signed Form
Enter the date the PA/HCA signed by the attending physician was received by the nurse or in the agency.

Element 28 — Name and Address — Attending Physician
Enter the attending physician's name and complete address. The street, city, state, and ZIP+4 code must be included. The attending physician establishes the POC, certifies, and recertifies the medical necessity of the visits and/or services provided.

Elements 29 and 30 — Signature and Date Signed — Attending Physician
The attending physician is required to sign and date the PA/HCA within 20 working days following the initial start of care. A recertification of the POC requires the attending physician to sign and date the new PA/HCA prior to the continued provision of services to the member.

Provider-created formats must contain the following statement accompanying the attending physician's signature:

"The member is under my care, and I have authorized the services on this plan of care."

Verbal authorization may be obtained from the attending physician for the initial certification period PA request. The member may then begin receiving home care services; however, the attending physician is required to sign the PA/HCA within 20 working days of the start of care date.

The attending physician may not give verbal authorization for certification period renewal PA requests. The attending physician is required to sign the PA/HCA prior to the continued provision of services to the member; home care services may not be provided until the attending physician's signature is obtained on the form.

The form may be signed by another physician who is authorized by the attending physician to care for the member in his or her absence.

The nurse or agency staff may not predate the PA/HCA for the attending physician or write the date in the field after it has been returned. If the attending physician has left Element 30 blank, the nurse or agency staff should enter the date the signed PA/HCA was received in Element 27.

Elements 31 and 32 — Countersignature and Date Signed — Nurse in Independent Practice
When two or more NIP share a case, it is necessary to designate only one RN who receives the physician's orders to complete Element 24. Often, the designated RN is also the case coordinator. Each NIP sharing the case is required to obtain a copy of the PA/HCA for the effective certification period and *countersign* and *date* Elements 31 and 32 to document that he or she has reviewed the POC and will execute it as written.

Provider-created formats must contain the following statement accompanying the authorized nurse's countersignature:

"As the nurse countersigning this plan of care, I confirm the following: All information on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this plan of care is carried out as specified."

ATTACHMENT 7
Prior Authorization/Home Care Attachment (PA/HCA) (for photocopying)

(A copy of the "Prior Authorization/Home Care Attachment [PA/HCA]" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, F-11096A, for information on completing this form.

SECTION I — MEMBER INFORMATION

1a. Name — Member	1b. Telephone Number — Member
2. Member Identification Number	
3. Start of Care Date	4. Certification Period From To

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment

8a. Functional Limitations

1 ❑ Amputation	5 ❑ Paralysis	9 ❑ Legally Blind
2 ❑ Bowel / Bladder (Incontinence)	6 ❑ Endurance	10 ❑ Dyspnea with Minimal Exertion
3 ❑ Contracture	7 ❑ Ambulation	11 ❑ Other (Specify in Element 8b)
4 ❑ Hearing	8 ❑ Speech	

8b. If “Other” checked in Element 8a, specify other functional limitations.

9a. Activities Permitted

1 ❑ Complete Bedrest	6 ❑ Partial Weight Bearing	10 ❑ Wheelchair
2 ❑ Bedrest BRP	7 ❑ Independent at Home	11 ❑ Walker
3 ❑ Up As Tolerated	8 ❑ Crutches	12 ❑ No Restrictions
4 ❑ Transfer Bed / Chair	9 ❑ Cane	13 ❑ Other (Specify in Element 9b)
5 ❑ Exercises Prescribed		

9b. If “Other” checked in Element 9a, specify other activities permitted.

10. Medications (Dose / Frequency / Route)

11. Allergies

Continued

12. Nutritional Requirements

13. Mental Status	1 ❑ Oriented	3 ❑ Forgetful	5 ❑ Disoriented	7 ❑ Agitated	
	2 ❑ Comatose	4 ❑ Depressed	6 ❑ Lethargic	8 ❑ Other _____	
14. Prognosis	1 ❑ Poor	2 ❑ Guarded	3 ❑ Fair	4 ❑ Good	5 ❑ Excellent

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

Continued

16. Goals / Rehabilitation Potential / Discharge Plans

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Member	18. Dates of Last Inpatient Stay Within 12 Months (If Known)		19. Type of Facility for Last Inpatient Stay (If Applicable)
	Admission	Discharge	

20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

21. Home or Social Environment

22. Medical and / or Nonmedical Reasons Member Regularly Leaves Home (Include Frequency)

Continued

23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

SECTION VI — SIGNATURES

Nurse Certification

As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

24. **SIGNATURE** — Authorized Nurse Completing Form	25. Date Signed — Authorized Nurse Completing Form

26. Date of Verbal Orders for Initial Certification Period	27. Date Received Physician-Signed Form

Physician Certification

The member is under my care, and I have authorized the services on this PA/HCA.

28. Name and Address — Attending Physician (Street, City, State, ZIP+4 Code)

29. **SIGNATURE** — Attending Physician	30. Date Signed — Attending Physician

Case Sharing Nurse in Independent Practice Certification

As the nurse countersigning this PA/HCA, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

31. **COUNTERSIGNATURE** — Nurse in Independent Practice (Only if Sharing Case)	32. Date Countersigned — Nurse in Independent Practice

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

ATTACHMENT 8
Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions

(A copy of the "Prior Authorization Home Health Therapy Attachment [PA/HHTA] Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Home Health Therapy Attachment (PA/HHTA), F-11044, to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth at the address listed below. If other home health services (e.g., nursing, aide services) are being provided in addition to home health therapy services, complete this attachment and submit it with the appropriate forms for the other services. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
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 — MEMBER INFORMATION

Element 1 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Member
Enter the age of the member in numerical form (e.g., 16, 21, 60).

Element 3 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist who would be responsible for and participate in home health therapy services for the member. If the rendering provider would be a certified therapy assistant, enter the name of the certified therapist who will be physically present at the residence to supervise the certified therapy assistant.

Element 5 — Therapist's National Provider Identifier (NPI)
Enter the National Provider Identifier (NPI) of the therapist who would provide the authorized service (rendering provider). If the rendering provider would be a therapy assistant, enter the NPI of the supervising therapist. *If the therapist does not have an NPI and is employed by or under contract to the agency, enter the agency's NPI.*

Element 6 — Telephone Number — Therapist
Enter the telephone number, including the area code, of the therapist who would provide the authorized service (rendering provider). If the rendering provider would be a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring/Prescribing Physician
Enter the name of the physician referring/prescribing the home health therapy evaluation and/or treatment.

Element 8 — Referring/Prescribing Physician's NPI
Enter the NPI of the physician referring/prescribing home health therapy services.

The remaining portions of this attachment are to be used to document the justification for home health therapy services.

SECTION III — DOCUMENTATION
Complete Elements 9 through 17. The provider may refer to specific sections of the attachments rather than duplicating information. For example, the provider may indicate on the attachment, "Refer to Element 3 of therapy evaluation."

Element 9
Provide a brief history pertinent to the service(s) requested.

Element 10
Provide a description of the member's diagnosis and problems as they pertain to the need for the therapy services requested. Include the date of onset.

Element 11
State therapy history. Include type/date/location for all types of therapy.

Element 12
Indicate the date of initial evaluation. Supply dates/tests/results of additional evaluations.

Element 13
Describe progress in measurable/functional terms since treatment was initiated or last authorized.

Element 14
Attach a Plan of Care indicating specific, measurable goals and procedures to meet those goals.

Element 15
Describe rehabilitation potential.

Element 16 — Signature — Requesting Provider
ForwardHealth requires the requesting provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 17 — Date Signed
Enter the month, day, and year the PA/HHTA was signed (in MM/DD/CCYY format).

Other Required Information

1. Attach a copy of the Physician's Plan of Care.
2. Attach a copy of the therapy evaluation.
3. If the request is for a member age 3 to 22, attach a copy of the Individualized Education Program or explain why there is none.
4. If the request is for a child under age 3, attach a copy of the Individual Family Service Plan or explain why there is none.

ATTACHMENT 9
Prior Authorization/Home Health Therapy Attachment (PA/HHTA) (for photocopying)

(A copy of the "Prior Authorization/Home Health Therapy Attachment [PA/HHTA]" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11044 (10/08)

STATE OF WISCONSIN
HFS 107.11(3), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions, F-11044A.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Age — Member

3. Member Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist

5. Therapist's National Provider Identifier (NPI)

6. Telephone Number — Therapist

7. Name — Referring / Prescribing Physician

8. Referring / Prescribing Physician's NPI

SECTION III — DOCUMENTATION

9. Provide a brief history pertinent to the service(s) requested.

10. Provide a description of the member's diagnosis and problems as they pertain to the need for the therapy services requested. (Include the date of onset.)

Continued

SECTION III — DOCUMENTATION (Continued)

11. State member's therapy history. (Indicate type / date / location for all types of therapy.)

Service Area	Location	Date	Problem Treated
Physical Therapy			
Occupational Therapy			
Speech and Language Pathology			

12. Indicate the date of initial evaluation. (Supply dates / tests used / results of additional evaluations.)

13. Describe progress in measurable / functional terms since treatment was initiated or last authorized.

14. Attach a plan of care indicating specific, measurable goals and procedures to meet those goals.

15. Describe rehabilitation potential.

16. **SIGNATURE** — Requesting Provider	17. Date Signed

ATTACHMENT 10
Private Duty Nursing Prior Authorization Acknowledgment

(A copy of the "Private Duty Nursing Prior Authorization Acknowledgment" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11041 (10/08)

STATE OF WISCONSIN
HFS 107.12(2), Wis. Admin. Code

FORWARDHEALTH

PRIVATE DUTY NURSING PRIOR AUTHORIZATION ACKNOWLEDGEMENT

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory.

INSTRUCTIONS

1. Allow the member, or member's parent, guardian, or legal representative, to read the plan of care and PA request. Answer any questions the member may have.

2. Have the member or the member's legal representative sign and date this form.

3. Attach this completed form to the Prior Authorization Request Form (PA/RF), F-11018, and/or Prior Authorization Amendment Request, F-11042. Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

4. For more information on private duty nursing documentation, contact Provider Services at (800) 947-9627.

Name — Member	Member Identification Number

I have read the attached Plan of Care and the PA request.

Name — Person Signing Form (Print)	Relationship to Member (If Person Signing Form Is Not Member)
SIGNATURE — Person Signing Form Check one of the following to identify person signing form. ❑ Member ❑ Member's Parent ❑ Guardian ❑ Legal Representative	Date Signed

DT-PA060-060

ATTACHMENT 11
Prior Authorization Amendment Request Completion Instructions

(A copy of the "Prior Authorization Amendment Request Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
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 — MEMBER INFORMATION

Element 1 — Original PA Number
Enter the unique PA number from the original PA to be amended.

Element 2 — Process Type
Enter the process type as indicated on the PA to be amended.

Element 3 — Member Identification Number
Enter the member ID as indicated on the PA to be amended.

Element 4 — Name — Member
Enter the name of the member as indicated on the PA to be amended.

SECTION II — PROVIDER INFORMATION

Element 5 — Billing Provider Number
Enter the billing provider number as indicated on the PA to be amended.

Element 6 — Name — Billing Provider
Enter the name of the billing provider as indicated on the PA to be amended.

SECTION III — AMENDMENT INFORMATION

Element 7 — Address — Billing Provider
Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

Element 8 — Requested Start Date
Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

Element 9 — Requested End Date (If Different from Expiration Date of Current PA)
Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different that the current expiration date.

Element 10 — Reasons for Amendment Request
Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

Element 11 — Description and Justification for Requested Change
Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

Element 12 — Are Attachments Included?
Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

Element 13 — Signature — Requesting Provider
Enter the signature of the provider that requested the original PA.

Element 14 — Date Signed — Requesting Provider
Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

ATTACHMENT 12
Prior Authorization Amendment Request (for photocopying)

(A copy of the "Prior Authorization Amendment Request" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11042 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

SECTION I — MEMBER INFORMATION

1. Original PA Number	2. Process Type	3. Member Identification Number

4. Name — Member (Last, First, Middle Initial)

SECTION II — PROVIDER INFORMATION

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

SECTION III — AMENDMENT INFORMATION

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)

10. Reasons for Amendment Request (Check All That Apply)

- ❑ Change Billing Provider Number
- ❑ Add Procedure Code / Modifier
- ❑ Change Procedure Code / Modifier
- ❑ Change Diagnosis Code
- ❑ Change Grant or Expiration Date
- ❑ Discontinue PA
- ❑ Change Quantity
- ❑ Other (Specify)_____

11. Description and Justification for Requested Change

12. Are Attachments Included? ❑ Yes ❑ No
If Yes, specify attachments below.

13. **SIGNATURE** — Requesting Provider	14. Date Signed — Requesting Provider