ForwardHealth
Wisconsin serving you

Update
July 2008

No. 2008-118

Affected Programs: BadgerCare Plus, Medicaid
To: Personal Care Agencies, HMOs and Other Managed Care Programs

Changes to Prior Authorization for Personal Care Services

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for personal care services, 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).
  - ✓ Personal Care Screening Tool (PCST), F-11133 (10/08).
  - ✓ Personal Care Prior Authorization Provider Acknowledgement, F-11134 (10/08).
  - ✓ Personal Care Addendum, F-11136 (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 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 personal care 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. Attachment 4 is a sample PA/RF for personal care 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 personal care services will be required to use the revised Personal Care Screening Tool (PCST), F-11133 (10/08), the Personal Care Prior Authorization Provider Acknowledgement, F-11134 (10/08), and the Personal Care Addendum, F-11136 (10/08). While the basic information requested on the forms has not changed, the format of the forms 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 5 for a copy of the completion instructions for the PCST. Attachment 6 is a copy of the PCST for providers to photocopy. Attachment 7 is a copy of the Personal Care Prior Authorization Provider Acknowledgement for providers to photocopy. Attachment 8 is a copy of the completion instructions for the Personal Care Addendum. Attachment 9 is a copy of the Personal Care Addendum for providers to photocopy.

Obtaining Prior Authorization Request Forms and Attachments

The PA/RF, PCST, Personal Care Prior Authorization Provider Acknowledgement, and Personal Care Addendum 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 or the PCST, Personal Care Prior Authorization Provider Acknowledgement, or Personal Care Addendum 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 via 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 10. Attachment 11 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.

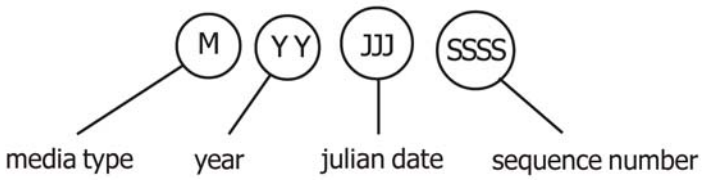
Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

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

P-1250

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 Personal Care Services

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 Personal Care Screening Tool, F-11133, 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 personal care services by a dually certified home health/personal care agency and "121" for services by a personal care only agency. The process type is a three-digit code used to identify a category of service requested. PA 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 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 provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider number 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 (e.g., September 8, 1966, would be 09/08/1966).

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 (not required)

Element 18 — Procedure Code
Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for each service/procedure/item requested.

Note: If the provider needs additional spaces for Elements 18-23 for the PA request, the provider may complete additional PA/RF(s). The PA/RFs should be identified, for example, as "page 1 of 2" and "page 2 of 2."

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

Element 20 — POS
Enter the appropriate place of service (POS) code designating where the requested service/procedure would be provided/performed/dispensed.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure/item requested.

When requesting personal care services, indicate the number of units per week multiplied by the total number of weeks being requested. The total number of units requested on the PA/RF must be equivalent to the number of hours ordered by the physician (4 units = 1 hour). If requesting travel time, enter this as a separate item using procedure code T1019 and modifier U3.

If sharing a case with another provider, enter "shared case with (name of provider)" and include a statement that the total number of units of all providers will not exceed the combined and total number of units ordered on the plan of care.

Element 22 — QR
Enter the appropriate quantity in units for the procedure code listed. To calculate total quantity requested, multiply the number of hours per week by the number of units per hour (4 units = 1 hour). Multiply that number by the number of weeks requested (e.g., hours/week x 4 units/hour x number of weeks). For example, 14 hours/week x 4 units/hour x 53 weeks = 2968 units.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," 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. If the provider completed a multiple-page PA/RF, indicate the total charges for the entire PA request on Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 should refer to the last page (for example, "SEE PAGE TWO").

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 Personal Care Services

(A sample copy of the "Prior Authorization Request Form [PA/RF]" for personal care 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)	**121**	**(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
401.9 — Hypertension NOS		

14. Diagnosis — Secondary 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
		T1019					**12**	**Personal care services 63 units, wk x 53 weeks**	**3,339**	**XXX.XX**
		T1019					**12**	**PRN personal care services 96 units/yr**	**96**	**XXX.XX**
		T1019	**U3**				**12**	**Personal care travel time 28 units/wk x 53 weeks**	**1,484**	**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	**XXX.XX**

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

ATTACHMENT 5
Personal Care Screening Tool (PCST) Completion Instructions

(A copy of the "Personal Care Screening Tool [PCST] Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PERSONAL CARE SCREENING TOOL (PCST)
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.

ForwardHealth requires persons who are requesting authorization for personal care services to complete and submit the Personal Care Screening Tool (PCST) as instructed. The PCST may be completed using a Web-based format that may be accessed at *https://www.dwd.state.wi.us/desltc/*, or providers may print and complete the paper format (F-11133) from the Forms page of the ForwardHealth Portal.

The use of this form is mandatory when requesting PA for personal care (PC) services. If more space is needed than is provided in the comment section, include the additional information on the Personal Care Addendum, F-11136 (09/06). Provide enough information for ForwardHealth to make a determination about the request.

Providers are required to submit either the PCST Summary Sheet, F-11137, or a completed paper version of the PCST and other documents as directed by ForwardHealth personal care policy when requesting PA for personal care services. Providers may submit PA documents 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 that are greater in number or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS

The PCST is a tool that collects information on an individual's ability to accomplish activities of daily living (ADL), instrumental ADL (IADL), medically oriented tasks (MOT), and the member's needs for personal care worker (PCW) assistance with these activities. The screener may not include services provided to the applicant by informal, unpaid supports such as family or friends. Whether the provider is using the Web-based or paper PCST, the PCST must be completed based on a face-to-face evaluation of the individual in his or her home. Only an authorized Adult Long Term Care Functional Screen (LTC FS) screener or agency-designated registered nurse (RN) may complete the PCST. Clerical entry of information into the PCST may be done by users to whom the Division of Disability and Elder Services has granted access; however, the information should be based on the authorized LTC FS screener or agency-designated RN's face-to-face visit.

Providers should take into account the time it takes an individual to complete a task. If it takes the individual a very long time to complete the task, consideration should be given to the need for PCW assistance to complete the task safely. However, if the extended time it takes an individual to complete a task does not interfere with his or her ability to complete that task safely, the provider should indicate that the individual is able to complete the task "independently."

When completing the elements in the ADL section, only one response should be selected when indicating the level of help needed (Elements 25-31). The only exception is Element 30 (Toileting); providers should indicate all responses that apply. When completing an element in this section, providers should first determine if assistance is needed with a task on at least a weekly basis. If assistance is needed at least weekly, the provider should select the most appropriate level of help from the choices listed in the element for that ADL. If the level of help varies, select the level of help that represents the level most often needed.

When completing the frequencies in Elements 25-34 and 38, the screener should enter frequencies that represent only the PCW services that the provider will provide. When one or more agencies will be sharing the case, the screener should enter frequencies that represent only the PCW services the case-sharing providers will provide.

Age-Appropriate Responses for Activities of Daily Living
Typically, children age five and younger require the assistance of an adult to complete many ADL. For those tasks that have an age range associated with them (i.e., bathing, dressing, grooming, eating, mobility, toileting, and transfers) and the child's age falls within the stated range, the "age appropriate" response should be selected. If it is determined that the task requires more assistance than an adult would typically provide to a child of that age, *and* the weekly number of units allocated do not meet the total needs, submit the following to ForwardHealth for nurse consultant review:

- An explanation in the comment section for the reason that more assistance is needed with that ADL.
- The Personal Care Addendum, F-11136 (including the plan of care [POC]).

WEB-BASED PERSONAL CARE SCREENING TOOL DISCLAIMER (WEB-BASED VERSION ONLY)
Providers who wish to use the Web-based PCST are required to read the following Web-Based PCST Disclaimer:

The Web-based Personal Care Screening Tool (PCST) contains language that is abbreviated from the paper PCST. Instructions for the paper PCST provide guidance to the authorized screener responding to questions in the paper and the Web-based PCST formats. The authorized screener should refer to the paper PCST and to the PCST instructions for complete details. The responses selected when completing the Web-based PCST should not be different from those that would be selected if the authorized screener were to complete the paper PCST.

By completing the Web-based PCST, you are acknowledging that you have read the above, understand the limitations of the Web-based PCST, and agree to the use of the PCST subject to the above terms.

SCREENING INFORMATION

Element 1a — Name — Screening Agency
Enter the name of the agency that will complete the PCST for the applicant.

Element 1b — Telephone Number
Enter the telephone number when submitting the paper PCST.

Element 2 — Screen Completion Date
Enter the date of the face-to-face evaluation of the applicant in MM/DD/CCYY format.

Element 3a — Name — Screener
Enter the name of the authorized adult LTC FS screener or agency-designated RN completing the PCST for the applicant.

Element 3b — Qualifications — Screener
Check the box identifying the screener's qualifications.

APPLICANT INFORMATION

Element 4 — Name — Applicant
Enter the last name, first name, and middle initial of the applicant being screened for personal care services.

Element 5 — Gender — Applicant
Check the appropriate box to indicate the applicant's gender.

Element 6 — Social Security Number — Applicant
Enter the applicant's Social Security number.

Element 7 — Address — Applicant
Enter the applicant's address, including street, city, state, and ZIP code.

Element 8 — Date of Birth — Applicant
Enter the applicant's date of birth in MM/DD/CCYY format.

Element 9 — Telephone Number — Applicant (Optional)
Enter the applicant's telephone number, including area code.

Element 10 — County / Tribe of Residence — Applicant
Enter the name of the county or tribe's borders in which the applicant resides.

Element 11 — County / Tribe of Responsibility — Applicant
Enter the name of the county or tribe that is responsible for the applicant's benefits.

Element 12 — Directions (Optional)
Enter driving directions to the applicant's home.

Element 13 — Medical Insurance
Check all appropriate boxes to indicate the type(s) of insurance the applicant holds. *The applicant's ForwardHealth member identification number is required when submitting a request for prior authorization.*

Element 14 — Race (Optional)
Check all appropriate boxes to indicate the applicant's race.

Element 15 — Ethnicity (Optional)
Check the box if the applicant's ethnicity is Spanish, Hispanic, or Latino.

Element 16 — Interpreter Services (Optional)
Check the appropriate box to indicate if the applicant requires the services of an interpreter. If "Yes" is checked, indicate the language for which the applicant requires interpretation services.

Element 17 — Responsible Party Contact Type (Optional)
Check the box that describes the responsible party's relationship to the applicant. The responsible party is a contact person other than the applicant.

Element 18 — Name — Responsible Party (Optional)
Enter the responsible party's last name, first name, and middle initial.

Element 19 — Telephone Numbers — Responsible Party (Optional)
Enter the responsible party's telephone number(s) and best time(s) to call.

Element 20 — Address — Responsible Party (Optional)
Enter the responsible party's address including street, city, state, and ZIP+4 code.

Element 21 — Comments (Optional)
Enter any comments about the responsible party.

Element 22 — Scheduled Activities Outside Residence
Check the appropriate box to indicate if the applicant regularly attends scheduled activities outside of his or her residence. If "Yes" is checked, enter the number of days per week that regularly scheduled activities occur. The applicant's complete schedule of regularly attended activities must be included in the applicant's medical file.

Element 23 — Diagnosis Codes
Enter up to three *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes that most directly relate to the applicant's need for personal care. At least one ICD-9-CM code is required.

Element 24 — Living Situation
Check the box that best describes the applicant's living situation.

ACTIVITIES OF DAILY LIVING

Element 25 — Bathing
"Bathing" means the ability to wash the entire body (excludes grooming, washing hands and face only, and bathing related to incontinence care) in the shower, tub, or with a sponge or bed bath for the purpose of maintaining adequate hygiene. This includes the ability to get in and out of the tub or shower, turning faucets on and off, regulating water temperature, wetting, soaping, and rinsing skin, shampooing hair, drying body, applying lotion to skin, and routine catheter care.

Bathing includes all transfers related to bathing. Examples of transfers include the following:

- Applicant needs to be physically transferred to a shower chair.

Select the response, A-F, that best describes the level of function the applicant possesses when bathing. For children age five or younger, select response "F." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate how many days per week PCW assistance is needed with bathing. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples

A. Applicant is able to bathe him- or herself in the shower or tub with or without an assistive device.

- Applicant requires use of a shower chair but is able to complete bathing safely without any assistance from another person.
- Applicant is able to bathe him- or herself without any assistance from another person.

B. Applicant is able to bathe him- or herself in the shower or tub but requires the presence of another person intermittently for supervision or cueing.

- Applicant needs intermittent cueing to shower, gather towel, wash, etc., and to turn on water so scalding does not occur. He or she is then safe alone in the shower so the person cueing can leave.
- Applicant needs occasional reminders to stay on task.
- Applicant requires supervision intermittently to ensure personal safety.

C. Applicant is able to bathe him- or herself in the shower or tub but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.

- Applicant requires continuous cues to complete bath but can bathe him- or herself. The caregiver is required to be continually present. If continuous cues were not provided, the caregiver would be required to physically assist with the bath.
- Applicant requires continual presence of another person and cannot be left alone as the applicant is confused and attempts to climb out of the bathtub. If the caregiver was not continually present, the person would require physical assistance to complete the bath.

D. Applicant is able to bathe in shower, tub, or bed with partial physical assistance from another person.

- Applicant is able to complete upper body bathing, but needs physical assistance with lower body bathing and application of lotion.
- Applicant needs physical assistance in and out of the tub, but can bathe self.
- Applicant requires a bed bath. Applicant is able to bathe upper body but needs physical assistance from another person to complete bathing of the lower body and provide routine care of an indwelling catheter.

E. Applicant is unable to effectively participate in bathing and is totally bathed by another person.

- Applicant is unable to assist with any aspect of bathing.
- Applicant is able to hold washcloth but is unable to effectively participate in washing body.

F. Applicant's ability is age appropriate for a child age five or younger.

- Child is five years old or younger.

Element 26 — Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device) as necessary. This includes fine motor coordination for buttons and zippers. Difficulties with a zipper or buttons *at the back* of a dress or blouse do not constitute a functional deficit.

For both the Upper Body and Lower Body categories, complete the following:

- Select the response, A-F, that best describes the level of function the applicant possesses when dressing. For children age five or younger, select response "F." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.
- Indicate the time of day when PCW assistance with dressing is needed.
- Indicate how many days per week PCW assistance is needed with dressing. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples

Upper Body

A. Applicant is able to dress upper body without assistance or is able to dress him- or herself if clothing is laid out or handed to the person.

- Applicant is independent in dressing upper body and does not need assistance.
- Applicant is able to dress upper body independently if clothing is placed in front of him or her.
- Applicant is able to dress upper body independently but needs someone to choose appropriate clothes.

B. Applicant is able to dress upper body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.

- Applicant can dress upper body independently, but needs someone to remind him or her to button the blouse and adjust the collar.
- Applicant requires cueing/instructing to fasten buttons on front of shirt.

C. Applicant is able to dress upper body by him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant requires constant cueing to complete each aspect of dressing the upper body, but can dress him- or herself. The applicant requires the full attention of the caregiver throughout the dressing activity. If continuous cues were not provided, the caregiver would be required to physically assist with dressing the upper body.

D. Applicant needs partial physical assistance from another person to dress the upper body.
- Applicant can put on shirt, but cannot physically button it.
- Applicant needs assistance pulling the shirt over the head.

E. Applicant depends entirely upon another person to dress the upper body.
- Applicant needs total assistance with dressing the upper body and is unable to effectively assist.

F. Applicant's ability is age appropriate for a child age five or younger.
- Child is five years old or younger.

Lower Body

A. Applicant is able to dress the lower body without assistance or is able to dress him- or herself if clothing and shoes are laid out or handed to the person.
- Applicant is independent in dressing the lower body and does not need assistance.
- Applicant is able to dress the lower body without assistance if clothing is placed in front of or handed to him or her.

B. Applicant is able to dress the lower body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- Applicant can dress the lower body independently but needs to be reminded intermittently by another person to button and/or zip pants.
- Applicant only needs intermittent verbal instruction to complete lower body dressing.
- Applicant requires supervision intermittently to ensure personal safety. Applicant has a history of falls.

C. Applicant is able to dress the lower body by him- or herself, but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant requires constant cueing to complete each aspect of dressing the lower body, but can dress him- or herself. The applicant requires the full attention of the caregiver throughout the dressing activity. If continuous cues were not provided, the caregiver would be required to physically assist with dressing the lower body.

D. Applicant needs partial physical assistance to dress the lower body.
- Applicant can pull on pants, but cannot button and/or zip them.
- Applicant needs assistance pulling up pants.

E. Applicant depends entirely upon another person to dress the lower body.
- Applicant needs total assistance with dressing the lower body and is not able to effectively assist.

F. Applicant's ability is age appropriate for a child age five or younger.
- Child is five years old or younger.

Prosthetics, Braces, Splints, and/or Anti-Embolism Hose

- Select "yes" if applicant needs assistance with placement or removal of a prosthetic, brace, splint, and/or anti-embolism hose. If the applicant does not need assistance, select "no." Do *not* check "yes" if the applicant needs assistance with placement or removal of any of the following items: hearing aids, eyeglasses, or dentures.

- Indicate the number of days per week PCW assistance is needed with placement and/or removal of a prosthetic, brace, splint, and/or anti-embolism hose. Do not count days and times of day in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Element 27 — Grooming

"Grooming" means the ability to tend to personal hygiene needs (i.e., washing face and hands, combing or brushing hair, shaving, nail care, applying deodorant, and oral or denture care).

Select the response, A-G, that best describes the level of function the applicant possesses when grooming. For children age five or younger, select response "G." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate the time of day when PCW assistance with grooming is needed. Indicate how many days per week PCW assistance is needed with grooming. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside the home.

Examples

A. Applicant is able to groom him- or herself, with or without the use of assistive devices or adapted methods.
- Applicant needs a chair placed due to being unsteady when standing, but can groom self if able to sit during the task.
- Applicant can groom him- or herself with specially adapted utensils.

B. Applicant is able to groom him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- Applicant needs to be cued to place toothpaste and brush teeth, but can physically perform task by him- or herself.
- Applicant needs to be supervised intermittently to ensure proper completion of tasks.

C. Applicant is able to groom him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant needs constant cueing to complete all tasks related to grooming, but can groom him- or herself. The caregiver is required to be continually present. If continuous cues were not provided, the caregiver would be required to physically assist with grooming.

D. Applicant needs physical assistance to set up grooming supplies, but can groom him- or herself.
- Applicant needs assistance putting toothpaste on toothbrush, but is able to complete other grooming by him- or herself.

E. Applicant needs partial physical assistance to groom him- or herself.
- Applicant is able to brush teeth and apply deodorant, but needs assistance combing hair and shaving.
- Applicant is able to partially complete the task, but requires assistance to fully complete grooming.
- Applicant is able to initiate tooth brushing, but is not able to effectively complete the task without the assistance of another person.

F. Applicant depends entirely upon another person for grooming.
- Applicant needs total assistance with all aspects of grooming.

G. Applicant's ability is age appropriate for a child age five or younger.
- Child is five years old or younger.

Element 28 — Eating

"Eating" means the ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

Select the response, 0 or A-H, that best describes the level of function the applicant possesses when eating. If the applicant is fed exclusively via tube feedings or intravenously, select response "0." If a member is fed orally *and* via tube feedings, select the most appropriate response A through G (also complete daily tube feedings under Element 34, as appropriate). For children age three or younger, select response "H." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate the meals with which the PCW will assist. Indicate how many days per week PCW assistance is needed for each meal. *Do not mark meals for which the PCW will not be providing assistance.* Do not count days in which unpaid caregivers will be providing the cares or when care is provided outside of the home. For example, an applicant requires partial feeding at lunch and is in a day program for five days per week; because PC may not be provided outside of the home, only two days of PCW assistance with lunch should be marked.

Examples

0. Applicant is fed exclusively via tube feedings or intravenously.
- Check this box if the applicant receives nutrition only through tube feedings or intravenously and is not fed orally.

A. Applicant is able to feed him- or herself, with or without use of an assistive device or adapted methods.
- Applicant is able to feed him- or herself with the use of adapted utensils.
- Applicant is able to feed him- or herself.

B. Applicant is able to feed him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- Applicant is able to feed him- or herself, but requires occasional cueing to keep on task.
- Applicant needs to be reminded to use portion control as well as what types of food are appropriate for a special diet.
- Applicant needs to be reminded to eat.

C. Applicant needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- Applicant needs assistance to cut meat, arrange food, or set up adaptive utensils.

D. Applicant is able to feed him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant needs to be constantly supervised for inappropriate behaviors while eating, but can feed him- or herself. The applicant requires the full attention of the caregiver throughout the eating activity. If continuous supervision was not provided, the caregiver would be required to physically assist with eating.

E. Applicant has a recent history of choking or the potential for choking, based on documentation.
- Applicant needs to be constantly monitored during eating to prevent choking, aspiration, or other serious complications due to a *documented* history of these problems.

F. Applicant needs partial physical feeding from another person.
- Applicant is able to feed him- or herself for a short period of time before being no longer able to do so. Assistance is needed to complete eating.
- Applicant is able to drink from an adapted cup by him- or herself, but requires someone to feed him or her solid foods.

G. Applicant needs total feeding from another person.
- Applicant depends entirely on someone else for feeding.

H. Applicant's ability is age appropriate for a child age three or younger.
- Child is three years old or younger.

Element 29 — Mobility in the Home
"Mobility in the home" means the ability to move between locations (i.e., ambulate) in the applicant's living environment, including the kitchen, living room, bathroom, and sleeping area. *This excludes basements, attics, yards, and any equipment used outside of the home.*

Select the response, 0 or A-E, that best describes the level of function the applicant possesses when moving between locations in the home, with or without help from an assistive device. Assistive devices include, but are not limited to, canes, crutches, walkers scooters, and wheelchairs. If the applicant remains bedfast, select response "0." For children age 18 months or younger, select response "E." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate how many days per week PCW assistance is needed with mobility in the home. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples
0. Applicant remains bedfast.

- Check this box only if the applicant remains bedfast and does not get out of bed.

A. Applicant is able to ambulate by him- or herself.
- Applicant is able to ambulate independently with the use of a cane or walker.
- Applicant is able to move wheelchair independently.

B. Applicant is able to ambulate by him- or herself, but requires presence of another person intermittently for supervision or cueing.
- Applicant needs to be reminded to stand up straight when using a walker.
- Applicant needs to be cued to move a wheelchair to a specific location.

C. Applicant is able to ambulate by him- or herself, but requires the constant presence of a PCW to provide immediate physical intervention.
- Applicant needs constant supervision, but does not need physical assistance with ambulation. The applicant requires the full attention of the caregiver throughout ambulatory activities. If continuous supervision were not provided, the caregiver would be required to provide physical assistance with mobility.

D. Applicant needs physical help from another person.
- Applicant needs physical assistance with moving a manual wheelchair within his or her home.
- Applicant needs physical assistance from one person plus a gait belt to assist with ambulation.
- Applicant needs hands-on physical assistance when ambulating.

E. Applicant's ability is age appropriate for a child 18 months or younger.
- Child is 18 months old or younger.

Element 30 — Toileting
Toileting includes transferring on and off the toilet, cleansing of self, changing of personal hygiene product, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers related to toileting.

Select the responses, A-G, that best describe the level of function the applicant possesses when toileting. **Select all responses that apply.**

For children age four or younger, select response "G." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

If responses "C," "D," "E," or "F" are selected, also include the frequency per day of the situation described in which the PCW will provide assistance. If the frequency varies, record the higher of the frequencies. For example, a member requires assistance with toileting and the PCW assists her six times a day on average. However, the member attends a day program five days per week and on those days, the PCW assists with toileting four times per day. The frequency entered in the PCST would be six times per day.

When toileting assistance is needed *only* for the bowel program, the screener should indicate assistance needed with the bowel program in Element 34, and not in the toileting section.

Indicate how many days per week PCW assistance with toileting is needed. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples

A. Applicant is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device.
   - Applicant needs a raised toilet seat and with its use can toilet self.
   - Applicant is incontinent, but can change his or her own incontinence product.

B. Applicant is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.
   - Applicant needs to be reminded to wipe him- or herself and wash his or her hands, but can toilet him- or herself.
   - Applicant requires cueing/instruction to pull his or her pants up after toileting.
   - Applicant needs to be intermittently supervised while in the bathroom to ensure proper completion of toileting.

C. Applicant is able to toilet him- or herself or provide his or her own incontinence care, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
   - Applicant requires constant cueing to complete each aspect of toileting, but can toilet him- or herself. The applicant requires the full attention of the caregiver throughout the toileting activity. If continuous cues were not provided, the caregiver would be required to physically assist with toileting activities.

   When estimating frequency, if the applicant is both constantly supervised during toileting and provided incontinence care during the same episode, then the episode should be counted under the incontinence frequency total. Do not total both constant supervision with toileting and incontinence care during the same episode.

   For example, the applicant is constantly supervised during toileting, generally six times per day. On average, the applicant is found incontinent two out of the six toiletings. The frequency should be indicated as constant supervision four times per day and incontinent two times per day.

D. Applicant needs physical help from another person to use toilet and/or change personal hygiene product.
   - Applicant needs assistance pulling up and buttoning his or her pants.
   - Applicant needs assistance with pulling down his or her pants, wiping, and washing his or her hands.
   - Applicant needs physical assistance to change a personal hygiene product (such as Depends or a feminine hygiene product.)
   - Applicant has stress incontinence and needs physical help changing a personal hygiene product.

   When estimating frequency, if the applicant is both toileted and provided incontinence care during the same episode, then the episode should be counted under the incontinence frequency total. Do not total both toileting and incontinence care during the same episode.

   For example, the applicant requests to be toileted but was also incontinent. This would be totaled as one episode of incontinence. In another example, the applicant is generally toileted six times a day, but may be discovered to be incontinent two out of the six toiletings. This would be totaled as four episodes of toileting and two episodes of incontinence.

E. Applicant needs physical help from another person for incontinence care. (Does not include stress incontinence.)
   - Applicant needs assistance changing incontinence product, providing peri-care, and assisting with an occasional change of clothes.

   When estimating frequency, if the applicant is both toileted and provided incontinence care during the same episode, then the episode should be counted under the incontinence frequency total. Do not total both toileting and incontinence care during the same episode.

For example, the applicant requests to be toileted but was also incontinent. This would be totaled as one episode of incontinence. In another example, the applicant is generally toileted six times a day, but may be discovered to be incontinent two out of the six toiletings. This would be totaled as four episodes of toileting and two episodes of incontinence.

F. Applicant needs physical help from another person to empty an ostomy or catheter bag.
- Applicant is unable to release clamp on ostomy bag and needs physical assistance to empty bag.

When estimating frequency, determine how many times per day the PCW will be assisting with emptying an ostomy or catheter bag. Do not count episodes in which the PCW will not be needed to provide the care.

G. Applicant's ability is age appropriate for a child age four or younger.
- Child is four years old or younger.

Element 31 — Transferring
"Transferring" means the physical ability to move between surfaces (e.g., from bed/chair to wheelchair or walker), the ability to get in and out of bed or usual sleeping place, and the ability to use assistive devices for transfers. Transferring excludes transfers related to bathing, and toileting.

Select the response, A-G, that best describes the level of function the applicant possesses when transferring. For children age three or younger, select response "G." If the child requires more assistance than an adult would typically provide to a child of that age, explain in the comment section why more assistance is needed.

Indicate how many days per week PCW assistance with transferring is needed. Do not count days in which unpaid caregivers will be providing the care or when care is provided outside the home.

Examples
A. Applicant is able to transfer him- or herself, with or without an assistive device.
- Applicant is able to transfer him- or herself to a wheelchair with the use of an assistive device.
- Applicant is able to transfer him- or herself with the use of crutches.

B. Applicant is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.
- Applicant needs to be reminded not to bear weight on a fractured foot.

C. Applicant is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- Applicant requires constant supervision when transferring, but is able to transfer him- or herself. The applicant requires the full attention of the caregiver throughout the transfer activities. If continuous supervision was not provided, the caregiver would be required to physically assist with transfers.

D. Applicant needs the physical help of another person but is able to participate (e.g., applicant can stand and bear weight).
- Applicant is able to bear weight and assist with a pivot transfer with the physical assistance of another person.

E. Applicant needs the constant physical help from another person and is unable to participate (e.g., applicant is unable to stand and pivot or is unable to bear weight).
- Applicant requires the assistance of another person with the use of a gait belt and the person is unable to effectively participate.

F. Applicant needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring.
- Applicant needs a Hoyer lift to be transferred.

G. Applicant's ability is age appropriate for a child age three or younger.
- Child is three years old or younger.

MEDICALLY ORIENTED TASKS (MOTs)

Element 32 — (Part I) Medication Assistance
Select the option that best describes the applicant's need for assistance with his or her medication(s). Medication assistance includes assistance with oral medications, topical patches, eye drops, ear drops, nasal spray, inhalers, medications administered via a gastrostomy tube, and suppositories not related to a bowel program. When assistance is needed with the application of legend skin care, indicate the need in Element 33. When assistance is needed with nebulizer treatments, indicate the need in Element 34.

Indicate how many days per week PCW assistance is needed with medication assistance. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

Examples

0. Not applicable.
   - Applicant has no medications.

A. Independent with medications with or without the use of a device.
   - Applicant is able to self-administer medications.
   - Applicant is independent with medications with the use of a pill box.

B. Needs reminders.
   - Applicant is able to self-administer medications, but requires another person or a device (e.g., electronic medication dispenser) to provide reminders.
   - Applicant requires instructions on how to take the medication (e.g., cueing him or her to place the medication in the mouth, take a drink, and swallow.)

C. Needs the physical help of another person.
   - A family member or friend assists applicant with taking his or her medications. (The PCW does not perform this task.)

D. Needs the physical help of a PCW.
   - Applicant requires assistance from a PCW to take medications.
   - Applicant requires PCW to place medication in his or her hand or mouth.

If response "D" is selected, indicate the number of times per day a PCW needs to assist the applicant with his or her medications.

Element 33 — (Part II) Tasks to be Performed by a PCW
Select the tasks to be completed by a PCW. If no PCW assistance is needed for a task, leave that task blank.

Indicate the frequency per day and days per week each task will be performed by a PCW. If the frequency per day varies, indicate the higher frequency. Do not count days in which other unpaid caregivers will be providing the care or when care is provided outside of the home.

Glucometer Readings. Allowed only when medical condition supports the need for ongoing, frequent monitoring, and the physician has established parameters on reporting readings. High blood sugars due to the noncompliance of a competent adult does not support the need for assistance of a PCW.

Skin Care. Skin care is the application of legend solutions, lotions, or ointments that are ordered by the physician due to skin breakdown, rashes, etc. Pro re nata (PRN) or "as needed" or prophylactic skin care is an ADL task that is covered under bathing. If the PCW will be providing prescribed skin care, the name of the drug and frequency prescribed must be indicated. If the applicant has more than one prescription ointment, indicate the one that occurs most frequently. Document other prescription ointments on the comment line. Prescription ointments related to wound care should be indicated in Element 34 under wound care.

Catheter Site Care. Cleaning a catheter site may be marked if the applicant requires PCW assistance with site care provided to a *suprapubic catheter* (drainage tube that extends from a small hole in the skin just above the pubic bone). "Site care" means that special care is given to the area where the catheter goes into the abdomen. Site care usually involves cleansing this area with soap and water and covering with dry gauze. Do not check this area for routine catheter care for an indwelling catheter. Routine catheter care usually involves soap and water as a normal part of bathing. Do not confuse site care for a suprapubic catheter with catheter care for an indwelling catheter.

Check "Other" under Other Program in Element 34 if the PCW will be providing irrigation of the catheter, changing and/or replacing the catheter, or "in & out" catheterization.

Gastrointestinal Tube Site Care. Cleaning a gastrostomy site may be marked if the applicant requires PCW assistance with site care provided to a gastrostomy or jejunostomy site (tube that extends from a small hole in the skin from the abdomen). "Site care" means that special care is given to the area where the tube goes into the abdomen. Site care is usually cleansing this area with soap and water and covering with dry gauze.

Complex Positioning. This is specialized positioning, including positioning required to change body positions while at a specific location for the purpose of maintaining skin integrity, pulmonary function, and circulation. When determining frequency, the positioning related to the tasks of bathing, dressing, and toileting are accounted in the times allotted for each specified task and are not to be counted separately.

Element 34 — (Part III) Tasks to Be Performed by a PCW — ForwardHealth Review and Manual Approval May Be Required
Complete this section for tasks the RN is delegating to a PCW. Tasks in this element will not be assigned time if they are not delegated by an RN. If no PCW assistance is needed for a task, leave that task blank.

Indicate the frequency per day and days per week each task will be performed by a PCW. Do not count days in which unpaid caregivers will be providing the care, or when care is provided outside of the home.

For tasks indicated in this element, manual review of the PA request will be required only when the total amount of time computed by the PCST is insufficient for a PCW to provide the delegated tasks identified in this element *and* additional time is being requested for those delegated tasks. Include the Personal Care Addendum, F-11136, the POC, and other documentation as directed when submitting the PA request.

Daily Tube Feedings. Administration of tube feedings is the process of giving nutrition via a tube inserted into a person's body. This may include a gastrostomy tube (g-tube), jejunostomy tube (j-tube), or a nasogastric tube (NG tube). Select this option when the applicant requires a PCW to administer a tube feeding. Do not select this option if the PCW is only monitoring the feeding while it is in progress. Administering includes starting and stopping the tube feeding and all tasks involved with starting or stopping a feeding, such as preparing the feeding, flushing the tube, hanging the bag, etc.

Continuous Feeding. Select continuous feeding if the applicant is receiving a continuous feeding and requires a PCW to administer it. A continuous feeding is a feeding that is not given intermittently throughout the day or given by bolus.

For example, an applicant receives continuous feeding; the PCW sets up the formula, flushes the tube, hangs the feeding bag and starts the feeding. The PCW does this once per day, three days per week. On the other days of the week, a family member administers the feeding. PCW frequency per day = 1, PCW days per week = 3.

Intermittent (Bolus) *Feeding*. Select intermittent (bolus) feeding if the applicant receives feedings at various times during the day and requires a PCW to administer them.

For example, an applicant receives bolus feedings (50cc each time) three times a day. The PCW will be administering the feeding two times per day, seven days per week. PCW frequency per day = 2, PCW days per week = 7.

Respiratory Assistance. Assistance needed with suctioning, chest physiotherapy (CPT), nebulizer treatments, or tracheostomy related care. Check all that apply.

Tracheostomy Care. Select tracheostomy care if the applicant requires cleaning of the tracheostomy site, changing of the tracheostomy tube, and/or changing of the tracheostomy straps or ties that hold the tube in place and assistance of the PCW is needed.

Note: In the comments section at the end of this element, specify the care that the PCW will be providing.

Suctioning. Select suctioning if the applicant requires suctioning of the oral cavity, the nasal cavity, the nasopharyngeal cavity, or of a tracheostomy and a PCW is performing the task.

Note: In the comments section at the end of this element, specify the type of suctioning the PCW will be performing.

Chest Physiotherapy. Select CPT if the applicant requires postural drainage or chest percussion and the PCW is performing the task.

Nebulizer. Select nebulizer if the applicant requires a PCW to administer respiratory treatment via a nebulizer.

Bowel Program. A bowel program is a regimen prescribed by a physician to develop proper bowel evacuation. A bowel program may include the use of suppositories, enemas, or digital stimulation. Assistance with a bowel program includes assistance with related hygiene needs. Indicate which task or tasks are being performed by the PCW as well as the frequency for each task. Each task indicated in this section must be performed by the PCW at least once per week.

Note: In the comments section, specify the specific bowel program the PCW will be providing.

Examples
- The PCW inserts a suppository, waits 30 minutes, and then provides digital stimulation to promote proper evacuation of the colon. This is completed every three days.
- The PCW gives the applicant a warm water enema once a week and requires assistance with post task hygiene.

Wound or Decubiti Care (excludes basic skin care). A wound or decubitus requiring dressing and care. "Wound" is defined as a wound from a serious burn, traumatic injury, or a serious infection. Select this response if the applicant has documentation of a wound or a decubitus and requires a PCW to provide wound cleaning and/or dressing. This does not include ostomy care.

For example, the applicant has a wound on the outer aspect of their ankle measuring 1 cm by 1 cm, red in color, and draining serosanguinous drainage. The wound is cleansed daily with normal saline and simple dry dressing (2x2) applied. The PCW will be providing wound care once per day, seven days per week. Frequency per day = 1, number of days per week = 7.

Note: In the comments section, include a description of the wound or decubitus and explain the wound care the PCW will be performing.

Therapy Program. Assistance with activities that are directly supportive of skilled therapy services. This includes activities that do not require the skills of a therapist to be safely and effectively performed. Activities may include routine maintenance exercises, e.g., range of motion (ROM) exercises and repetitive speech routines. *In order to be medically necessary, the activities must be ordered in conjunction with a therapy program or as a result of a therapy evaluation and ordered by the physician.* The therapist may screen the member as often as medically necessary to verify the continuing medical necessity of activities supportive of therapy, such as ROM, repetitive speech drills, and other routine exercise programs. A full therapy evaluation by a therapist is needed when there is a change in client condition or when the home exercise program is not accomplishing its goals.

For example, the applicant has seen a physical therapist and the therapist has written a passive ROM program that the person needs physical assistance completing.

Note: When submitting the PA request, a copy of the therapy program developed by a therapist **must** be submitted and the activities must be included in the physician orders.

Range of Motion. Assistance with ROM that is not directly supportive of skilled therapy services. Do not select this if you have selected ROM under Therapy Program. A physician's order is required along with documentation supporting the medical necessity for ROM. The need for ROM must be directly supported by the member's diagnosis and medical condition (e.g., ROM to the left side due to left hemiparesis following a cerebrovascular accident). Typically, ROM that is not part of a prescribed therapy program should be able to be completed during routine ADL. If ROM is unable to be completed during routine ADL, the documentation must include information as to why it cannot be completed during these activities. Documentation must also include a description of the ROM the PCW will be assisting with (e.g., ROM to all four extremities once a day) and an explanation as to why the ROM activities cannot be completed without the physical assistance of a PCW.

For example, the applicant has chronic contractures of the upper extremities and requires passive ROM to prevent further decline. In this situation, the ROM is ordered by a physician, but it is neither directly supportive of skilled therapy services nor is it part of an active therapy program that has been prescribed by a therapist.

Note: When submitting a PA request for more time than the PCST has allocated and ROM has been selected, a Personal Care Addendum, F-11136, must be completed and submitted and include a description of the ROM with which the PCW will be assisting, the reason the member cannot complete ROM during routine ADL, and the reason the member cannot complete ROM without the physical assistance of a PCW. The POC with the physician's order for ROM by a PCW must also be submitted with the PA request.

Vital Signs. Allowed only when medical condition support the need for ongoing, frequent monitoring, and the physician has established parameters at which point a change in treatment may be required. Vital signs include temperature, blood pressure, pulse, and respiratory rates.

Other. List the medically oriented tasks prescribed by a physician that are not included among the other MOT listed in the PCST. The tasks listed in "Other" are RN-delegated tasks to be performed by a PCW. Examples could include catheter irrigations, catheter insertions, and ostomy appliance changes. Do not select "other" if applicant uses a mechanical lift for transfers. If a mechanical lift is needed for assistance with transfers, refer to Element 31 and select response "F."

Note: When submitting a PA request for MOT listed in "Other", include a detailed description of the MOT to be provided by the PCW.

INCIDENTAL SERVICES

Element 35

Services incidental to the ADL and MOT include changing the applicant's bed, laundering the applicant's bed linens and personal clothing, care of eyeglasses (also contact lenses) and hearing aids, light cleaning in essential areas of the home used during PC services, purchasing food, preparing the applicant's meals, and cleaning the applicant's dishes. (Refer to the Personal Care page of the Online Handbook section of the Provider area of the ForwardHealth Portal.) Indicate if services incidental to the ADL and MOT will be performed by the PCW.

BEHAVIORS AND MEDICAL CONDITIONS

Element 36 — Behaviors

Indicate if the applicant exhibits more often than once per week behavior that makes ADL tasks more time consuming for the PCW to complete. If "Yes" is checked, list the behavior(s) and describe how the behavior(s) make the ADL and MOT tasks more time consuming for the PCW to complete.

Examples

- Applicant hits and kicks PCW while trying to complete the activities of bathing, dressing, and grooming.
- Applicant is physically resistive to all care completed by the PCW.

Element 37 — Medical Conditions

Indicate if the applicant has any medical conditions that make ADL and MOT tasks more time consuming for a PCW to complete and are expected to result in a long-term need for extra care. If "Yes" is checked, list the medical condition(s) and describe how it increases the amount of time for the PCW to complete the ADL and MOT tasks.

Examples

- Applicant has severe contractures and additional time is needed to safely complete personal care tasks without injuring him or her.
- Applicant experiences severe shortness of breath due to chronic obstructed pulmonary disease and requires additional time for completion of tasks.

Element 38 — Seizures

If the applicant has a diagnosis of seizures, indicate the time frame of the last seizure. Specify the seizure type, frequency, and the date of the last seizure. Specify if the PCW will provide seizure interventions and list the interventions he or she will perform.

PRO RE NATA, INCLUDING MEDICAL APPOINTMENTS

Element 39 — Pro Re Nata Including Time to Accompany Applicant to Medical Appointments

Time needed for PRN includes time to accompany the applicant to medical appointments and/or time for short duration episodes of acute need for PC services. Indicate if PRN is needed for a PCW to accompany the applicant to medical appointments and/or to provide PC services during short duration episodes of acute need for PC services.

BILLING PROVIDER INFORMATION (PAPER PCST ONLY)

Element 40 — Name — Billing Provider

Enter the name of the Medicaid-certified provider billing services provided to the member. Providers sharing the case are required to indicate that the case is shared and to include on the PA/RF the names of the agencies sharing the case. Check the box to indicate that the applicant will be served by other providers under a case-sharing arrangement.

Element 41 — Billing Provider Number

Enter the billing provider number.

Element 42 — Address — Billing Provider

Enter the billing provider's address, including street, city, state, and ZIP code.

SIGNATURE (PAPER PCST ONLY)

Element 43 — SIGNATURE — Authorized Screener

The authorized screener completing this PCST is required to sign this form.

Element 44 — Date Signed — Authorized Screener

Enter the date the authorized screener completing this PCST signed the form.

PCST SUMMARY SHEET INSTRUCTIONS (WEB-BASED PCST ONLY)

The PCST Summary Sheet will be produced for Web-based users after all information is entered into the PCST. This summary will contain the allocation of units for the applicant and other important alerts and information for the provider about PA submission. At the bottom of the PCST Summary Sheet, enter the following information:

- Billing provider name.
- Billing provider address.
- Billing provider number.
- Case sharing arrangements. (Providers sharing the case are required to indicate that the case is shared and to include on the PA/RF the names of the agencies sharing the case.)

ATTACHMENT 6
Personal Care Screening Tool (PCST)
(for photocopying)

(A copy of the "Personal Care Screening Tool [PCST]" is located on the following pages.)

FORWARDHEALTH

PERSONAL CARE SCREENING TOOL (PCST)

Instructions: Print or type clearly. Refer to the Personal Care Screening Tool (PCST) Completion Instructions, F-11133A, for information on completing this form.

SCREENING INFORMATION

1a. Name — Screening Agency 1b. Telephone Number	2. Screen Completion Date

3a. Name — Screener

3b. Qualifications — Screener ❑ Registered Nurse ❑ Certified Adult LTC Functional Screener ❑ Other

APPLICANT INFORMATION

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

5. Gender — Applicant ❑ Male ❑ Female	6. Social Security Number — Applicant
7. Address — Applicant (Street, City, State, ZIP Code)	8. Date of Birth — Applicant
	9. Telephone Number — Applicant (Optional)
10. County / Tribe of Residence — Applicant	11. County / Tribe of Responsibility — Applicant

12. Directions (Optional)

13. Medical Insurance

Check all that apply:

- ❑ Medicare (Specify Identification Number) _____.
  - ❑ Part A Effective Date (If Known) _____.
  - ❑ Part B Effective Date (If Known) _____.
  - ❑ Medicare Managed Care.
- ❑ ForwardHealth (Specify Member Number) _____.
- ❑ Private Insurance (Includes Employer-Sponsored [Job Benefit] Insurance).
- ❑ Private Long Term Care Number _____.
- ❑ Railroad Retirement (Specify Number) _____.
- ❑ Other Insurance.
- ❑ No medical insurance at this time.

Continued

APPLICANT INFORMATION (Continued)

14. Race (Optional)

Check all boxes that apply.

- ❑ Black or African American
- ❑ Asian or Pacific Islander
- ❑ White
- ❑ American Indian or Alaskan Native
- ❑ Other _____

15. Ethnicity (Optional)

- ❑ Spanish / Hispanic / Latino

16. Interpreter Services (Optional)

Is an interpreter required? ❑ Yes ❑ No

If so, in what language?

- ❑ 01 American Sign Language
- ❑ 02 Spanish
- ❑ 03 Vietnamese
- ❑ 04 Hmong
- ❑ 05 Russian
- ❑ 06 Other _____
- ❑ 07 A Native American Language

17. Responsible Party Contact Type (Optional)

- ❑ Adult Child
- ❑ Ex-spouse
- ❑ Guardian of Person
- ❑ Parent / Stepparent
- ❑ Power of Attorney
- ❑ Sibling
- ❑ Spouse
- ❑ Other Informal Caregiver / Support _____

18. Name — Responsible Party (Last, First, Middle Initial) (Optional)

19. Telephone Number(s) — Responsible Party (Optional)
Home:
Work:
Cell:
Best time to call:

20. Address — Responsible Party (Street, City, State, ZIP Code) (Optional)

21. Comments (Optional)

22. Scheduled Activities Outside the Residence (Include a schedule of activities in the applicant's medical file.)

Does the applicant regularly attend scheduled activities outside the residence? ❑ Yes ❑ No

If yes, how many days per week do regularly scheduled activities occur? _____

23. Diagnosis Codes

List up to three *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes that most directly relate to the applicant's need for personal care. At least one ICD-9-CM code is required.

ICD-9-CM Code 1_____

ICD-9-CM Code 2_____

ICD-9-CM Code 3_____

Continued

APPLICANT INFORMATION (Continued)

24. Living Situation (Indicate where the applicant currently lives.)

Own Home or Apartment
- ❑ Alone includes person living alone who receives in-home services.
- ❑ With Spouse / Partner / Family.
- ❑ With Nonrelative / Roommates includes dormitory, convent, or other communal setting.
- ❑ With Live-in Paid Caregiver(s) includes service in exchange for room and board.

Someone Else's Home or Apartment
- ❑ Family.
- ❑ Nonrelative.
  - ❑ 1-2 Bed Adult Family Home (Certified) or Other.
- ❑ Paid Caregiver's Home.
- ❑ Home / Apartment for Which Lease is Held by Support Services Provider.

Apartment with Services
- ❑ Residential Care Apartment Complex.
- ❑ Independent Apartment Community-Based Residential Facility.

Group Residential Care Setting
- ❑ Licensed Adult Family Home (three to four-bed home).
- ❑ Community-Based Residential Facility with 1-20 Beds.
- ❑ Community-Based Residential Facility with More than 20 Beds.
- ❑ Children's Group Home.

Health Care Facility / Institution
- ❑ Nursing Home includes rehabilitation facility.
- ❑ Intermediate Care Facility for Mental Retardation.
- ❑ Developmental Disability Center / State Institution for Developmental Disabilities.
- ❑ Mental Health Institute / State Psychiatric Institution.
- ❑ Other Institution for Mental Disease.
- ❑ Child Caring Institution.
- ❑ Hospice
- ❑ No Permanent Residence (e.g., a homeless shelter).

Other
- ❑ Specify (e.g., jail): _____

ACTIVITIES OF DAILY LIVING

25. Bathing

"Bathing" means the ability to wash the entire body (excludes grooming, washing hands and face only, and bathing related to incontinence care) in the shower, tub, or with a sponge or bed bath for the purpose of maintaining adequate hygiene. This includes the ability to get in and out of the tub or shower, turning faucets on and off, regulating water temperature, wetting, soaping, and rinsing skin, shampooing hair, drying body, applying lotion to skin, and routine catheter care. Bathing includes all transfers related to bathing.

Select the response, A-F, that best describes the level of function the applicant possesses when bathing.

- ❑ A. Applicant is able to bathe him- or herself in the shower or tub, with or without an assistive device.
- ❑ B. Applicant is able to bathe him- or herself in the shower or tub, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to bathe him- or herself in shower or tub, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant is able to bathe in shower, tub, or bed with partial physical assistance from another person.
- ❑ E. Applicant is unable to effectively participate in bathing and is totally bathed by another person.
- ❑ F. Applicant's ability is age appropriate for a child age five or younger.

Indicate how many days per week personal care worker assistance is needed with bathing: _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

26. Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device) as necessary. This includes fine motor coordination for buttons and zippers. Difficulties with a zipper or buttons *at the back* of a dress or blouse do not constitute a functional deficit.

Upper Body
Select the response, A-F, that best describes the level of function the applicant possesses when dressing his or her upper body.

- ❑ A. Applicant is able to dress the upper body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.
- ❑ B. Applicant is able to dress the upper body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to dress the upper body by him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs partial physical assistance from another person to dress the upper body.
- ❑ E. Applicant depends entirely upon another person to dress the upper body.
- ❑ F. Applicant's ability is age appropriate for a child age five or younger.

Indicate when PCW assistance with dressing the upper body is needed:

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the upper body: _____

Lower Body
Select the response, A-F, that best describes the level of function the applicant possesses when dressing his or her lower body.

- ❑ A. Applicant is able to dress the lower body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.
- ❑ B. Applicant is able to dress the lower body by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to dress lower body by him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs partial physical assistance from another person to dress the lower body.
- ❑ E. Applicant depends entirely upon another person to dress the lower body.
- ❑ F. Applicant's ability is age appropriate for a child age five or younger.

Indicate when PCW assistance with dressing the lower body is needed:

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the lower body: _____

Prosthetics, Braces, Splints and/or Anti-Embolism Hose

Indicate whether or not PCW assistance is needed with placement and/or removal of a prosthetic, brace, splint, or anti-embolism hose:

❑ Yes ❑ No

Indicate how many days per week PCW assistance is needed with placement and/or removal of a prosthetic, brace, splint, or anti-embolism hose: _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

27. Grooming

"Grooming" means the ability to tend to personal hygiene needs (i.e., washing face and hands, combing or brushing hair, shaving, nail care, applying deodorant, and oral or denture care).

Select the response, A-G, that best describes the level of function the applicant possesses when grooming.

- ❑ A. Applicant is able to groom him- or herself, with or without the use of assistive devices or adapted methods.
- ❑ B. Applicant is able to groom him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to groom him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs physical assistance to set up grooming supplies, but can groom him or her self.
- ❑ E. Applicant needs partial physical assistance to groom him- or herself.
- ❑ F. Applicant depends entirely upon another person for grooming.
- ❑ G. Applicant's ability is age appropriate for a child age five or younger.

Indicate when PCW assistance with grooming is needed:

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with grooming: _____

Comments _____

28. Eating

"Eating" means the ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

Select the response, 0 or A-H, that best describes the level of function the applicant possesses when eating. If member is fed orally *and* via tube feedings, select the most appropriate response A through F for the oral feedings. Complete the daily tube feedings under Element 34 as appropriate.

- ❑ 0. Applicant is fed exclusively via tube feedings or intravenously.
- ❑ A. Applicant is able to feed him- or herself, with or without use of assistive device or adapted methods.
- ❑ B. Applicant is able to feed him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- ❑ D. Applicant is able to feed him- or herself, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ E. Applicant has recent history of choking or potential for choking, based on documentation.
- ❑ F. Applicant needs partial physical feeding from another person.
- ❑ G. Applicant needs total feeding from another person.
- ❑ H. Applicant's ability is age appropriate for a child age three or younger.

Indicate the meals for which PCW assistance is needed:

❑ Breakfast ❑ Lunch ❑ Dinner ❑ None

Indicate how many days per week PCW assistance is needed for each meal:

Breakfast _____ Lunch _____ Dinner _____ ❑ Not Required

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

29. Mobility in the Home

"Mobility in the home" means the ability to move between locations (i.e., ambulate) in the applicant's living environment, including the kitchen, living room, bathroom, and sleeping area. **This excludes basements, attics, yards, and any equipment used outside the home.**

Select the response, 0 or A-E, that best describes the level of function the applicant possesses when moving between locations in the home with or without an assistive device. Assistive devices include, but are not limited to, canes, crutches, walkers, scooters, and wheelchairs.

- ❑ 0. Applicant remains bedfast.
- ❑ A. Applicant is able to ambulate by him- or herself.
- ❑ B. Applicant is able to ambulate by him- or herself, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to ambulate by him- or herself, but requires the constant presence of PCW to provide immediate physical intervention.
- ❑ D. Applicant needs physical help from another person.
- ❑ E. Applicant's ability is age appropriate for a child 18 months or younger.

Indicate how many days per week PCW assistance is needed with mobility in the home: ____

Comments _____

30. Toileting

Toileting includes transferring on and off the toilet, cleansing of self, changing of personal hygiene product, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers related to toileting.

Select the responses, A-G, that best describe the level of function the applicant possesses when toileting. *Select all responses that apply* and, as requested, include the frequency per day.

- ❑ A. Applicant is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device.
- ❑ B. Applicant is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to toilet him- or herself or provide his or her own incontinence care, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.

  _____Estimated frequency per day that PCW assistance is needed with toileting.
- ❑ D. Applicant needs physical help from another person to use the toilet and/or change a personal hygiene product.

  _____Estimated frequency per day that PCW assistance is needed with toileting.
- ❑ E. Applicant needs physical help from another person for incontinence care. (Does not include stress incontinence.)

  _____Estimated frequency per day that PCW assistance is needed with incontinence care.
- ❑ F. Applicant needs physical help from another person to empty an ostomy or catheter bag.

  _____Estimated frequency per day that PCW assistance is needed with ostomy or catheter care.
- ❑ G. Applicant's ability is age appropriate for a child age four or younger.

Indicate how many days per week PCW assistance is needed for toileting: ____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

31. Transferring
"Transferring" means the physical ability to move between surfaces (e.g., from bed/chair to wheelchair or walker), the ability to get in and out of bed or usual sleeping place, and the ability to use assistive devices for transfers. Transferring excludes transfers related to bathing and toileting.

Select the response, A-G, that best describes the level of function the applicant possesses when transferring.

- ❑ A. Applicant is able to transfer him- or herself, with or without an assistive device.
- ❑ B. Applicant is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs the physical help of another person, but is able to participate (e.g., applicant can stand and bear weight).
- ❑ E. Applicant needs constant physical help from another person and is unable to participate (e.g., applicant is unable to stand and pivot or is unable to bear weight).
- ❑ F. Applicant needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring.
- ❑ G. Applicant's ability is age appropriate for a child age three or younger.

Indicate how many days per week PCW assistance is needed with transferring: ____

Comments _____

MEDICALLY ORIENTED TASKS

32. (**Part I**) Medication Assistance

Select the appropriate response.

- ❑ 0. Not applicable.
- ❑ A. Independent with medications, with or without the use of a device.
- ❑ B. Needs reminders.
- ❑ C. Needs the physical help of another person, not a PCW.
- ❑ D. Needs the physical help of a PCW.

  Frequency per day: _____

Indicate how many days per week PCW assistance is needed with medication assistance: _____

Comments _____

33. (**Part II**) Tasks to be Performed by a PCW

Select the tasks to be completed by a PCW. Indicate the frequency per day and days per week each task will be performed.

- ❑ Glucometer Readings (Allowed when medical condition supports the need for ongoing, frequent monitoring and the physician has established parameters.)

  PCW Frequency Per Day _____ PCW Days Per Week _____

Continued

MEDICALLY ORIENTED TASKS (Continued)

33. (**Part II**) Tasks to be Performed by a PCW (Continued)

❑ Skin Care (Application of prescription ointments.)

Name of prescription medication _____

Frequency prescribed _____

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Catheter Site Care (Only for suprapubic catheters.)

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Gastrointestinal Tube Site Care

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Complex Positioning

PCW Frequency Per Day _____ PCW Days Per Week _____

Comments _____

34. (**Part III**) Tasks to Be Performed by a PCW **— ForwardHealth Review and Manual Approval May Be Required**

Select the tasks to be completed by a PCW as delegated by the registered nurse. Indicate the frequency per day and days per week each task will be performed. For tasks indicated in this element, manual review of the prior authorization (PA) request will be required only when the total amount of time computed by the PCST is insufficient for a PCW also to provide the delegated medical tasks identified in this element *and* additional time is being requested for those delegated medical tasks. Include the Personal Care Addendum, F-11136, the plan of care, and other documentation as directed when submitting the PA request.

Daily Tube Feedings (Nasogastric or Gastrostomy)

❑ Continuous Feeding PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Intermittent (Bolus) Feeding PCW Frequency Per Day _____ PCW Days Per Week _____

Respiratory Assistance (Check all that apply.)

❑ Tracheostomy Care PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Suctioning PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Chest Physiotherapy PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Nebulizer PCW Frequency Per Day _____ PCW Days Per Week _____

Bowel Program (Check all that apply.)

❑ Suppository PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Enema PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Digital Stimulation PCW Frequency Per Day _____ PCW Days Per Week _____

Continued

MEDICALLY ORIENTED TASKS (Continued)

34. (**Part III**) Tasks to Be Performed by a PCW **—** ForwardHealth Review and Manual Approval May Be Required (Continued)

Other Program (Check all that apply.)

❑ **Wound or Decubiti Care (Excludes Basic Skin Care)**
PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Therapy Program (Therapy plan prescribed by a physical therapist, occupational therapist, or speech-language pathologist within the last 12 month period.)**

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Range of Motion (Ordered by a physician, but not part of a prescribed therapy program.)**

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Vital Signs (Allowed when medical condition supports the need for ongoing, frequent monitoring, and the physician has established parameters.)**

PCW Frequency Per Day_____ PCW Days Per Week _____

❑ **Other (Specify all tasks that apply.)**

_____ PCW Frequency Per Day _____ PCW Days Per Week _____

_____ PCW Frequency Per Day _____ PCW Days Per Week _____

Comments _____

INCIDENTAL SERVICES

35. Will services incidental to the ADL and MOTs, be performed by the PCW?

Incidental services include changing the applicant's bed, laundering the applicant's bed linens and personal clothing, care of eyeglasses (also contact lenses) and hearing aides, light cleaning in essential areas of the home used during personal care services, purchasing food, preparing the applicant's meals, and cleaning the applicant's dishes. (Refer to the Personal Care page of the Online Handbook section of the Provider area of the ForwardHealth Portal.)

❑ Yes ❑ No

BEHAVIORS AND MEDICAL CONDITIONS

36. Behaviors

Does the applicant exhibit more often than once per week behavior that makes ADL and MOTs more time consuming for the PCW to complete?

❑ Yes ❑ No

If "Yes," list the behavior(s) and describe how the behavior(s) makes the ADL and MOTs more time consuming for the PCW to complete:

Continued

BEHAVIORS AND MEDICAL CONDITIONS (Continued)

37. Medical Conditions

Does the applicant have any medical conditions that make ADL and MOTs more time consuming for a PCW to complete?

❑ Yes ❑ No

If "Yes," list the medical condition(s) (e.g., severe contractures, hemiplegia, severe shortness of breath) and describe how the condition(s) makes the ADL and MOTs more time consuming for the PCW to complete.

38. Seizures

Does the applicant have a diagnosis of seizures? ❑ Yes ❑ No

If "Yes," complete the following.

Date of last seizure was:

❑ A. 0 - 90 days ago.
❑ B. 91 - 180 days ago.
❑ C. More than 180 days ago.

Specific Seizure Type _____

Frequency of Seizures _____

Date of Last Seizure _____

Does the PCW provide interventions? ❑ Yes ❑ No

If "Yes," list interventions.

PRO RE NATA, INCLUDING MEDICAL APPOINTMENTS

39. Pro Re Nata (PRN), Including Time to Accompany Applicant to Medical Appointments

Does the applicant need PRN for a PCW to accompany him or her to medical appointments and/or for assistance during short duration episodes of acute need for PC services?

❑ Yes ❑ No

BILLING PROVIDER INFORMATION

40. Name — Billing Provider

❑ Check if case sharing. Names — Other Agencies Sharing the Case:

41. Billing Provider Number

42. Address — Billing Provider (Street, City, State, ZIP+4 Code)

SIGNATURE

As the authorized screener completing this PCST, 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.

43. **SIGNATURE** — Authorized Screener

44. Date Signed — Authorized Screener

ATTACHMENT 7
Personal Care Prior Authorization Provider Acknowledgement (for photocopying)

(A copy of the "Personal Care Prior Authorization Provider Acknowledgement" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11134 (10/08)

STATE OF WISCONSIN
HFS 107.112(3), Wis. Admin. Code

FORWARDHEALTH
PERSONAL CARE PRIOR AUTHORIZATION PROVIDER 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 Personal Care Prior Authorization Provider Acknowledgement, F-11134, states that the *supervising registered nurse (RN)* will perform *each* of the following tasks *before* personal care (PC) services are provided for the claims submitted to ForwardHealth:

- Obtain physician's signed and dated orders.
- Conduct an assessment at the member's place of residence.
- Develop the plan of care (POC).

The use of this form is mandatory when requesting PA.

Providers are required to submit the Personal Care Prior Authorization Provider Acknowledgement and other documents as directed by ForwardHealth PC policy to ForwardHealth when requesting PA for PC services. Providers may submit PA documents 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 that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Instructions: Type or print clearly.

Name — Personal Care Services Provider	Provider Number
Name — Member	Member ID
As the authorized representative of the billing provider, I will assure that the supervising RN completes the following tasks before PC services are provided for the claims submitted to ForwardHealth: the physician's signed and dated orders for this member will be obtained, an assessment at the member's place of residence will be conducted, and a POC will be completed for this member.	
SIGNATURE — Authorized Representative of the Billing Provider	Date Signed

DT-PA064-064

ATTACHMENT 8
Prior Authorization Addendum Completion Instructions

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

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FORWARDHEALTH
PERSONAL CARE ADDENDUM 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 Personal Care Addendum, F-11136, may be completed to supply additional information when requesting PA or for members requesting an amendment to a PA request. The use of this form is mandatory when supplying additional information when requesting PA or for members requesting an amendment to a PA request. 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 Personal Care Addendum. Attach a copy of the Personal Care Addendum to a copy of the plan of care, any additional supporting materials that justify or explain the requested changes, and other documents as directed by ForwardHealth personal care (PC) policy. Providers may submit PA documents 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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. 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 — Name — Provider
Enter the name of the ForwardHealth-certified PC agency providing services to the member.

Element 2 — Provider Number
ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

SECTION II — MEMBER INFORMATION

Element 3 — 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 4 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

SECTION III — GENERAL ASSESSMENT

Element 5 — Skilled Visits Required by Member
Enter an "X" next to all visits required by the member.

If the member is eligible for Medicare, cannot reasonably obtain services outside the residence, and requires a skilled service, Medicare must be maximized before claims may be submitted to ForwardHealth, including disposable medical supplies and durable medical equipment. However, providers should request PA for all ForwardHealth-covered services, including those billed to other payers.

Element 6 — Communication Capability
Enter an "X" next to the statement that most closely matches the manner in which the member makes his or her needs known.

Element 7 — Hearing Aid Usage
Enter an "X" to indicate whether or not the member wears a hearing aid.

If the member wears a hearing aid, enter an "X" next to the statement that most closely matches his or her ability to hear while using the hearing aid.

Element 8 — Vision Correction
Enter an "X" to indicate whether or not the member wears corrective lenses.

If the member wears corrective lenses, enter an "X" next to the statement that most closely matches his or her ability to see while using the corrective lenses.

Element 9 — Orientation
Enter an "X" next to the statement that most closely describes the member's orientation awareness to the present environment in relation to time, place, and person.

Element 10 — Medications
Enter all medications prescribed for the member. Include the dosage, frequency, route, and start and stop dates for each medication listed.

This information is required regardless of which provider or agency administers or assists with administration of the medications.

Element 11 — Supporting Rationale for Requested Increase of Units
Document the specifics and supporting rationale for the increase in requested units. Attach additional pages if necessary.

SECTION IV — SOCIAL INFORMATION

Element 12 — Social / Economic / Cultural Factors
Identify and explain any social, economic, and/or cultural factors of the member that may impact the need for PC services or how the services are provided.

Element 13 — Scheduled Activities Outside Residence
Enter an "X" to indicate if the member attends regularly scheduled activities outside his or her place of residence.

If the member attends regularly scheduled activities outside his or her residence, provide the weekly schedule for these activities. Specify the times of day each activity takes place (e.g., 8 a.m.-3 p.m., school).

SECTION V — HISTORY OF CONDITION

Element 14 — Condition / Past and Present Problems Affecting Personal Care
Enter the member's condition and any past or present problems that directly affect the provision of PC services.

SECTION VI — STAFFING SCHEDULE

Element 15 — Staffing Schedule of Each Agency or Provider Providing Services
Enter the scheduled times that each agency or provider provides services to the member and indicate the funding source. Staffing may vary on a day-to-day basis at the convenience of the member. Agencies/providers may not vary schedule times without the approval of the member. Specify the times of day each provider provides services. If the schedule varies, enter the schedule that most closely resembles the services usually provided (e.g., PCW 8am-10am, HHAide 10am-2pm, PCW 6pm-8pm).

Element 16 — Other Information
Document any other information that supports the need for PC services and the justification for the time that is required to provide the services. Attach additional pages if necessary.

SECTION VII — SIGNATURE

Element 17 — SIGNATURE — Authorized Nurse Completing Form
The registered nurse (RN) completing this Personal Care Addendum is required to sign this form.

Element 18 — Date Signed
Enter the date that the RN completing this Personal Care Addendum signed the form.

ATTACHMENT 9
Prior Authorization Addendum Form
(for photocopying)

(A copy of the "Prior Authorization Addendum" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11136 (10/08)

STATE OF WISCONSIN
HFS 107.13(2), Wis. Admin. Code

FORWARDHEALTH
PERSONAL CARE ADDENDUM

Instructions: Print or type clearly. Refer to the Personal Care Addendum Completion Instructions, F-11136A, for information on completing this form.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. Provider Number

SECTION II — MEMBER INFORMATION

3. Name — Member	4. Member Identification Number

SECTION III — GENERAL ASSESSMENT

5. Skilled Visits Required by Member (Check all that apply.)

- ❑ Registered Nurse
- ❑ Licensed Practical Nurse
- ❑ Home Health Aide
- ❑ Physical Therapist
- ❑ Occupational Therapist
- ❑ Speech-Language Pathologist

6. Communication Capability (Check one.)

- ❑ Communicates needs verbally.
- ❑ Communicates verbally with difficulty, but can be understood.
- ❑ Communicates with sign language, symbol board, written messages, gestures, or interpreter.
- ❑ Communicates inappropriate content, makes garbled sounds.
- ❑ Does not communicate needs.
- ❑ Child with age-appropriate communication.

7. Hearing Aid Usage

Does the member wear a hearing aid? ❑ Yes ❑ No

If yes, what is the member's ability to hear with the hearing aid, if customarily worn? (Check one, if applicable.)

- ❑ No hearing impairment.
- ❑ Hearing difficulty at level of conversation.
- ❑ Hears and understands only very loud sounds (e.g., person speaking to member must yell to be heard.)
- ❑ No useful hearing; unable to interpret audible sounds.
- ❑ Not determined.

8. Vision Correction

Does the member wear corrective lenses? ❑ Yes ❑ No

If yes, what is the member's ability to see with corrective lenses, if customarily worn? (Check one, if applicable.)

- ❑ Has no impairment of vision.
- ❑ Has difficulty seeing at level of print, but may be able to read large or thick print.
- ❑ Has difficulty seeing obstacles in environment.
- ❑ Has no useful vision.
- ❑ Not determined.

Continued

SECTION III — GENERAL ASSESSMENT (Continued)

9. Orientation (Check one.)

- ❑ Oriented
- ❑ Minor forgetfulness of the following (Check all that apply.)
  - ❑ Time
  - ❑ Medications
  - ❑ Place
  - ❑ Meals
  - ❑ Person
- ❑ Partial or intermittent periods of disorientation in the following (Check all that apply.)
  - ❑ a.m.
  - ❑ Consistently
  - ❑ p.m.
  - ❑ Inconsistently
  - ❑ Two Hours or Less
- ❑ Totally disoriented — does not know time, place, or identity
- ❑ Comatose
- ❑ Not determined

10. Medications

Medication Name	Dosage / Frequency	Route	Start Date	End Date

11. Supporting Rationale for Requested Increase of Units

Continued

SECTION IV — SOCIAL INFORMATION

12. Social / Economic / Cultural Factors

13. Scheduled Activities Outside Residence

Does the member attend regularly scheduled activities outside his or her residence? ❑ Yes ❑ No

If yes, specify in the following table the times of day for each activity.

Scheduled Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
School							
Work							
Day Program							
Other (Specify) _____							
Other (Specify) _____							

SECTION V — HISTORY OF CONDITION

14. Condition / Past and Present Problems Affecting Personal Care

Continued

SECTION VI — STAFFING SCHEDULE

15. Staffing Schedule of Each Agency or Provider Providing Services

Specify the times of day each provider provides services.

Level of Care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Skilled Nursing Services							
Home Health Aide Services							
Personal Care Worker Services							
Case Sharing (Specify agency[ies]) _____							
Other (Specify, e.g., Home and Community-Based Waiver Services Worker) _____							

16. Other Information

SECTION VII — SIGNATURE

17. **SIGNATURE —** Authorized Nurse Completing Form	18. Date Signed

ATTACHMENT 10
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. 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 11
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