

Affected Programs: BadgerCare Plus, Medicaid

To: County Mental Health Coordinators, HealthCheck “Other Service” Providers, HMOs and Other Managed Care Programs

Changes to Prior Authorization for Child/Adolescent Day Treatment Services

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for child/adolescent day treatment 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 dhfs.wisconsin.gov/ForwardHealth/:
 - ✓ Prior Authorization Request Form (PA/RF), F-11018 (10/08).
 - ✓ Prior Authorization Amendment Request, F-11042 (10/08).
 - ✓ Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), F-11040 (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 and Family Services (DHFS) 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 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, child/adolescent day treatment services providers submitting a paper PA request 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 child/adolescent day treatment 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, child/adolescent day treatment service providers submitting a paper PA request will be required to use the revised Prior Authorization/ Child/Adolescent Day Treatment Attachment (PA/CADTA), F-11040 (10/08). While the basic information requested on the form has not changed, the format of the form has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Refer to Attachment 7 for a copy of the completion instructions for the PA/CADTA. Attachment 8 is a copy of the PA/CADTA for providers to photocopy.

Obtaining Prior Authorization Request Forms and Attachments

The PA/RF and PA/CADTA are available in fillable PDF or fillable Microsoft® Word from the Forms page at dhfs.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 use the fillable PDF, click on the dash-outlined boxes and enter the information. Press the “Tab” key to move from one box to the next.

To request a paper copy of the PA/RF or PA/CADTA 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 5.

Attachment 6 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 and Family Services (DHFS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHFS.

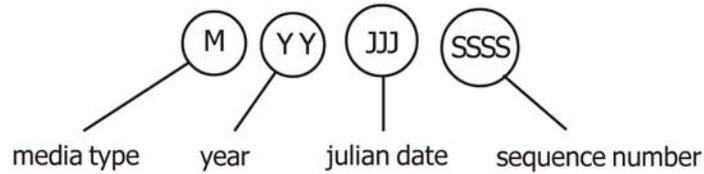
For questions, call Provider Services at (800) 947-9627 or visit our Web site at dhfs.wisconsin.gov/forwardhealth/.

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ATTACHMENT 1

Interpreting Prior Authorization Numbers

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



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

ATTACHMENT 2

Prior Authorization Request Form (PA/RF)

Completion Instructions for

Child/Adolescent Day Treatment 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 Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), F-11040, 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.”

Element 2 — Process Type

Enter process type “129” to indicate mental health day treatment services. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing 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 National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number

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

Element 7 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member

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

Element 9 — Name — Member

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

Element 10 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description

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

Element 12 — Start Date — SOI (not required)

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

Element 14 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date

Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests.

Element 16 — Rendering Provider Number (not required)

Element 17 — Rendering Provider Taxonomy Code (not required)

Element 18 — Procedure Code

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

Element 19 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed.

Element 20 — POS

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

Element 21 — Description of Service

Enter a written description corresponding to the appropriate HCPCS code for each service/procedure/item requested.

Element 22 — QR

Enter the total hours for the period requested.

Element 23 — Charge

Enter the total charges for the number of hours entered in Element 22.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

Element 24 — Total Charges

Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed

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

ATTACHMENT 3
Prior Authorization Request Form (PA/RF)
(For Photocopying)

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

ATTACHMENT 4

Sample Prior Authorization Request Form (PA/RF) for Child/Adolescent Day Treatment Services

(The sample "Prior Authorization Request Form [PA/RF]" for child/adolescent day treatment services is located on the following page.)

ATTACHMENT 5

Prior Authorization Amendment Request Completion Instructions

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

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FORWARDHEALTH PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

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

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

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

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

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

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

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1 — Original PA Number

Enter the unique PA number from the original PA to be amended.

Element 2 — Process Type

Enter the process type as indicated on the PA to be amended.

Element 3 — Member Identification Number

Enter the member ID as indicated on the PA to be amended.

Element 4 — Name — Member

Enter the name of the member as indicated on the PA to be amended.

SECTION II — PROVIDER INFORMATION

Element 5 — Billing Provider Number

Enter the billing provider number as indicated on the PA to be amended.

Element 6 — Name — Billing Provider

Enter the name of the billing provider as indicated on the PA to be amended.

SECTION III — AMENDMENT INFORMATION

Element 7 — Address — Billing Provider

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

Element 8 — Requested Start Date

Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

Element 9 — Requested End Date (If Different from Expiration Date of Current PA)

Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different than 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 6
Prior Authorization Amendment Request
(For Photocopying)

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

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

<input type="checkbox"/> Change Billing Provider Number	<input type="checkbox"/> Add Procedure Code / Modifier
<input type="checkbox"/> Change Procedure Code / Modifier	<input type="checkbox"/> Change Diagnosis Code
<input type="checkbox"/> Change Grant or Expiration Date	<input type="checkbox"/> Discontinue PA
<input type="checkbox"/> Change Quantity	<input type="checkbox"/> 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
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ATTACHMENT 7

Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) Completion Instructions

(A copy of the “Prior Authorization/Child/Adolescent Day Treatment Attachment [PA/CADTA] Completion Instructions” is located on the following pages.)

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FORWARDHEALTH PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA) 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 number (HFS 104.02[4], Wis. Admin. Code).

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

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

Attach the completed Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), F-11040, the physician prescription/order, evidence of a HealthCheck screen, and required documentation to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

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

GENERAL INSTRUCTIONS

The information contained in this PA/CADTA will be used to make a decision about the amount of child/adolescent day treatment that will be approved for ForwardHealth reimbursement. Complete each section as completely as possible. Where noted in these instructions, the provider may attach material from his or her records.

Initial Prior Authorization Request

Complete the PA/RF and the entire PA/CADTA and attach the HealthCheck referral and physician order dated not more than one year prior to the requested first date of service (DOS). Label all attachments (e.g., "Day Treatment — Treatment Plan"). The initial authorization will be for a period of no longer than three months.

First Reauthorization

Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the initial authorization request. Attach a summary of the treatment to date and any revisions to the day treatment services plan. Note progress on short- and long-term goals from the original plan. Be explicit in the summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second Reauthorization

Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the previous authorization requests. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent Reauthorizations

Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the previous authorization request. Attach a summary of the treatment since the previous authorization. Address why the member has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial authorization, first reauthorization, second reauthorization, or subsequent reauthorization request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple Services

When a member will require PA for other services concurrent to the child/adolescent day treatment (e.g., in-home treatment), a separate PA request must be submitted for those services along with the appropriate PA attachment and all required materials. The coordination of these concurrent services needs to be clearly indicated within the clinical documentation for all services. Other services must be identified on the multidisciplinary treatment plan(s).

SECTION I — MEMBER INFORMATION

Element 1 — 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 2 — Age — Member

Enter the age of the member in numerical form (e.g., 16).

Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Day Treatment Provider

Enter the name of the Medicaid-certified day treatment provider that will be billing for the services.

Element 5 — Day Treatment Provider's National Provider Identifier

Enter the National Provider Identifier for the day treatment provider.

Element 6 — Name — Contact Person

Enter the name of a person who would be able to answer questions about this request.

Element 7 — Telephone Number — Contact Person

Enter the telephone number of the contact person.

SECTION III — DOCUMENTATION

Element 8

Indicate the requested start date and end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the requested start date is prior to when the PA request will be received by ForwardHealth and backdating is needed, specifically request backdating and state clinical rationale for starting services before authorization is obtained. Requests may be backdated up to 10 working days on the initial authorization if appropriate rationale is provided.

Element 9

Indicate the total number of hours for which the provider is requesting ForwardHealth reimbursement for this PA grant period. The total number of hours should equal the quantity requested in Element 22 of the PA/RF.

Element 10

Present or attach a summary of the diagnostic assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. Not all ForwardHealth-covered child/adolescent day treatment services are appropriate or allowable for all diagnoses. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent day treatment practice, and clear documentation of the probable effectiveness of the proposed service. **Providers may attach a copy of a recent diagnostic assessment.**

Note: A substance abuse assessment may be included. A substance abuse assessment must be included if substance abuse-related programming is part of the member's treatment program.

Element 11

If the member is on psychoactive medication, the treatment plan must include the name of the physician managing the medication(s). Describe or attach a summary of the member's illness/treatment/medication history. For individuals with significant substance abuse problems, the multidisciplinary treatment plan should indicate how these will be addressed. *Providers may attach copies of illness/treatment/medication histories that are contained in their records.*

Element 12

Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (SED).

a. List the primary diagnosis and diagnosis code in the space provided. Not all ForwardHealth-covered child/adolescent day treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.

b. Complete the checklist for determining whether an individual would substantially meet the criteria for SED.

c. Check all applicable boxes. The individual must have one symptom or two functional impairments.

1. Symptoms

- Psychotic symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
- Suicidality — The individual must have made one attempt within the last three months or have had significant ideation about or have made a plan for suicide within the past month.
- Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

2. Functional Impairments (compared to expected developmental level)

- Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
- Functioning in the community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and a value system that result in potential or actual involvement in the juvenile justice system.
- Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
- Functioning in the family — Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness), inability to conform to reasonable limitations, and expectations that may result in removal from the family or its equivalent.
- Functioning at school/work — Impairment in any *one* of the following:
 - ✓ Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence toward others.
 - ✓ Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with a supervisor and other workers, or hostile behavior on the job.

d. Check all applicable boxes:

The individual is receiving services from two or more of the following service systems:

- Mental health.
- Social services.
- Child protective services.
- Juvenile justice.
- Special education.

Eligibility criteria are waived under the following circumstance.

- Individual substantially meets the criteria for SED except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach explanation.
- Substantially meets the criteria for SED except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

Element 13

Describe the treatment program that will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The information presented should be adequate for determining that those services for which reimbursement is requested are ForwardHealth reimbursable.

Element 14

If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. If less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.

Element 15

Indicate the expected duration of day treatment. Describe services expected to be provided following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, it is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION IV — ATTACHMENTS AND SIGNATURE

Element 16

The following materials must be attached and labeled.

- a. Attach a copy of a physician's prescription/order dated not more than one year prior to the requested first DOS.
- b. Attach verification that a HealthCheck screen has been performed by a valid HealthCheck screener not more than one year prior to the requested first DOS.
- c. The treatment team must complete a multidisciplinary day treatment services plan. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The treatment plan must be tailored for the individual member.

The plan must clearly identify how specific program components relate to specific treatment goals. The documented methods should allow for a clear determination that the services provided meet criteria for ForwardHealth covered services. Services that are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

- d. Submit a copy of a substance abuse assessment if the psychiatric assessment indicates significant substance abuse problems and substance abuse-related services will be a part of the day treatment program. The assessment may be summarized in Element 10 as part of the psychiatric assessment or illness history. If the substance abuse problems will be addressed by some other agency, this should be indicated in the multidisciplinary treatment plan.

Element 17 — Signature — Day Treatment Program Director

The PA/CADTA request must be signed by the day treatment program director (psychologist or psychiatrist*).

Element 18 — Date Signed

Enter the month, day, and year the PA/CADTA was signed in MM/DD/CCYY format.

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of healthcare providers in psychology.

ATTACHMENT 8
Prior Authorization/Child/Adolescent
Day Treatment Attachment (PA/CADTA)
(For Photocopying)

(A copy of the "Prior Authorization/Child/Adolescent Day Treatment Attachment [PA/CADTA]" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT
(PA/CADTA)

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 Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) Completion Instructions, F-11040A.

Initial Request First Reauthorization Second Reauthorization Subsequent Reauthorization

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Age — Member
3. Member Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Day Treatment Provider	5. Day Treatment Provider's National Provider Identifier
6. Name — Contact Person	7. Telephone Number — Contact Person

SECTION III — DOCUMENTATION

8. Indicate the requested start date and end date for this authorization period. If the requested start date is earlier than the date the prior authorization request form is first received by ForwardHealth, specifically request backdating and state clinical rationale for starting services before PA is obtained.

9. Indicate the number of hours of treatment to be provided over the PA grant period. Indicate the pattern of treatment (e.g., three hours per day, three days per week for eight weeks).

Continued



SECTION III — DOCUMENTATION (Continued)

The following additional information must be provided. If copies of existing records are attached to provide the information requested, *limit attachments to two pages for the psychiatric evaluation and illness / treatment history*. Highlighting relevant information is helpful. *Do not attach M-Team summaries, additional social service reports, court reports, or similar documents unless directed to do so following initial review of the documentation.*

-
10. Present a summary of the member's diagnostic assessment and differential diagnosis. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. *Diagnoses on all five axes of the most recent American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) are required.*

SECTION III — DOCUMENTATION (Continued)

11. Summarize the member's illness / treatment / medication history and other significant background information. Indicate why the provider thinks day treatment will produce positive change.

SECTION III — DOCUMENTATION (Continued)

12. Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. *The disability must be evidenced by a, b, c, and d listed below.*

- a. A primary psychiatric diagnosis of mental illness or severe emotional disorder. Document diagnosis using the most recent version of the APA DSM.

Primary Diagnosis Code and Description

- b. **The individual must meet all three of the following conditions:**

- Individual is under the age of 21.
- Individual's emotional and behavioral problems are severe in nature.
- The disability for which the individual is seeking treatment is expected to persist for a year or longer.

- c. **Symptoms and functional impairments**

The individual must have one of the following symptoms or two of the following functional impairments:

1. Symptoms

- Psychotic symptoms.
- Suicidality.
- Violence.

2. Functional impairments

- Functioning in self care.
- Functioning in the family.
- Functioning in the community.
- Functioning at school / work.
- Functioning in social relationships.

- d. **The individual is receiving services from two or more of the following service systems:**

- Mental health.
- Juvenile justice.
- Social services.
- Special education.
- Child protective services.

Eligibility criteria are waived under the following circumstances:

- The individual substantially meets the criteria for SED, except that the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach an explanation.
- The individual substantially meets the criteria for SED, except that the individual has not yet received services from more than one system and, in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

13. Describe the treatment program that will be provided. Attach a day treatment program schedule, if available. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this member's treatment goals.

SECTION III — DOCUMENTATION (Continued)

14. Indicate the rationale for day treatment. Elaborate on this choice if prior outpatient (clinic) treatment is absent or limited. Why does the member need this level of intervention at this time?

15. Indicate the expected date for termination of day treatment. Describe the anticipated service needs following completion of day treatment and the transition plan.

SECTION IV — ATTACHMENTS AND SIGNATURE

16. The following materials must be attached and *labeled*:

- a. A physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist, dated not more than one year prior to the requested first date of service (DOS).
- b. Documentation that the member had a comprehensive HealthCheck screen dated not more than one year prior to the requested DOS. A copy of this documentation must be attached for reauthorizations. (A copy of the original documentation may be used.) *The initial request for these services must be received by ForwardHealth within one year of when the HealthCheck screen was dated.*
- c. A multidisciplinary day treatment services plan. The treatment plan must be signed by a psychiatrist or psychologist.* Per HFS 40.10(4), Wis. Admin. Code, a psychiatrist or Ph.D. psychologist shall sign the treatment plan, signifying the services identified in the plan are necessary to meet the mental health needs of the child. Revisions in treatment plans also need to be approved by the program psychiatrist or Ph.D. psychologist.
- d. A substance abuse assessment may be included. A substance abuse assessment *must* be included if substance abuse-related programming is part of the member's treatment program.

I attest to the accuracy of the information on this PA request.

17. **SIGNATURE** — Day Treatment Program Director

18. Date Signed

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.