ForwardHealth
Wisconsin serving you

Update
June 2008

No. 2008-70

Affected Programs: BadgerCare Plus, Medicaid
To: Federally Qualified Health Centers, Home Health Agencies, Individual Medical Supply Providers, Medical Equipment Vendors, Nursing Homes, Occupational Therapists, Pharmacies, Physical Therapists, Rehabilitation Agencies, Speech and Hearing Clinics, Speech-Language Pathologists, Therapy Groups, HMOs and Other Managed Care Programs

Changes to Prior Authorization for Durable Medical Equipment

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for durable medical equipment, 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/Durable Medical Equipment Attachment (PA/DMEA), F-11030 (10/08).
  - ✓ Prior Authorization/Oxygen Attachment (PA/OA), F-11066 (10/08).
  - ✓ Record of Actual Daily Oxygen Use, F-11067 (10/08).
  - ✓ STAT-PA System Instructions, F-11055 (10/08).
  - ✓ STAT-PA Orthopedic Shoes Worksheet, F-11052 (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.
- Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) at (800) 947-1197.
- 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 durable medical equipment (DME) 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 DME. Attachment 5 is a sample PA/RF for DME exceptional supplies for members residing in a nursing home.

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 DME will be required to use the revised Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), F-11030 (10/08) or the revised Prior Authorization/Oxygen Attachment (PA/OA), F-11066 (10/08) with the revised Record of Actual Daily Oxygen Use, F-11067 (10/08) when necessary. While the basic information requested on the forms has not changed, the format of these 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 8 for a copy of the completion instructions for the PA/DMEA and Attachment 9 for a copy of the PA/DMEA for providers to photocopy. Refer to Attachment 10 for a copy of the PA/OA completion instructions and Attachment 11 for a copy of the PA/OA for providers to photocopy. Attachment 12 includes the Record of Actual Daily Oxygen Use completion instructions and Attachment 13 includes a copy of the Record of Actual Daily Oxygen Use form for providers to photocopy.

Revised STAT-PA System Instructions and Forms

ForwardHealth has revised the Wisconsin Specialized Transmission Approval Technology, or STAT-PA System Instructions, F-11055 (10/08), to accommodate NPI requirements and the ForwardHealth interChange system capabilities. The revised STAT-PA System Instructions are included as Attachment 14.

Refer to Attachment 15 for a quick reference guide for STAT-PA inquiries.

The STAT-PA Orthopedic Shoes Worksheet, F-11052 (10/08) has also been revised. Refer to Attachment 16 for a copy of the STAT-PA Orthopedic Shoes Worksheet completion instructions. Attachment 17 is a copy of the STAT-PA Orthopedic Shoes Worksheet for providers to photocopy.

Note: Prior authorizations cannot be approved through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan. Prior authorization requests for members enrolled in the Benchmark Plan may be submitted online via the Portal or on paper.

Obtaining Prior Authorization Request Forms and Attachments

The PA/RF, PA/DMEA, PA/OA, Record of Actual Daily Oxygen Use, and STAT-PA Orthopedic Shoes Worksheet are all 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, PA/DMEA, PA/OA, Record of Actual Daily Oxygen Use, or STAT-PA Orthopedic Shoes Worksheet 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; however, X-rays and photographs will be returned once the PA is finalized. Therefore, providers are required to make a copy of their PA requests (including attachments and additional 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 6. Attachment 7 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; however, X-rays and photographs will be returned once the amendment request is finalized. Therefore,

providers are required to make a copy of their amendment requests (including attachments and any additional 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.

Submitting Additional Supporting Documentation

Additional supporting clinical documentation is information that is included with a PA request such as X-rays or photographs. At implementation, providers must mail X-rays and photographs that are submitted with paper PA requests.

Watch for future publications for information on options that are available for providers submitting additional documentation with Portal PA requests.

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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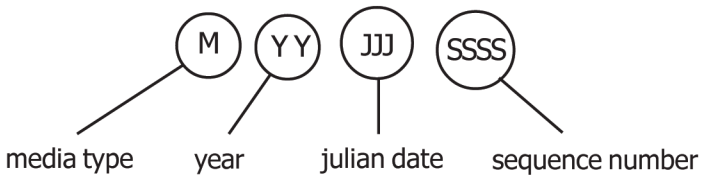
ATTACHMENT 1
Interpreting Prior Authorization Numbers

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 Durable Medical Equipment

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 for certain procedures, services, and 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/Durable Medical Equipment Attachment (PA/DMEA), F-11030, or the Prior Authorization/Oxygen Attachment (PA/OA), F-11066, 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 the appropriate three-digit process type from the list below. The process type is a three-digit code used to identify a category of service requested. Use process type 999 (Other) only if the requested category of service is not found in the list. Prior authorization requests will be returned without adjudication if no process type is indicated.

130 — Durable Medical Equipment (DME) (wheelchairs, accessories, home health equipment)
139 — DME (respiratory equipment or exceptional supplies)
140 — DME (orthotics, footwear, prosthetics)
999 — Other (use only if the requested category or service is not listed above)

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 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 (not required)

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 if a modifier is required.

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 appropriate quantity (e.g., number of services) requested for the procedure code listed.

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

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

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

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

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

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

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

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

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

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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

SECTION I — PROVIDER INFORMATION

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

SECTION II — MEMBER INFORMATION

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

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

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

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

24. Total Charges	

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

DT-PA049-049

ATTACHMENT 4
Sample Prior Authorization Request Form (PA/RF) for Durable Medical Equipment

(The sample "Prior Authorization Request Form [PA/RF]" for durable medical equipment 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)	**130**	**(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
436 Acute, but ill-defined cerebrovascular disease		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
342.9 Hemiplegia, unspecified	

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
		K0004					**12**	**High-strength, lightweight wheelchair, Invacare Patriot**	**1**	**XXXX.XX**
		K0108					**12**	**Headrest with hardware**	**1**	**XXX.XX**
		K0108					**12**	**Custom drop seat**	**1**	**XX.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
Sample Prior Authorization Form (PA/RF) for Exceptional Supplies Provided to Members Residing in a Nursing Home

(The sample "Prior Authorization Request Form [PA/RF]" for exceptional supplies provided to members residing in a nursing home 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)	**139**	**(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
518.81 Acute respiratory failure		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
V55.0 Tracheostomy	

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
0111111110	**123456789X**	**E1399**					**31**	**Trach care kit**	**60**	**XXX.XX**
0111111110	**123456789X**	**E1399**					**31**	**Trach suction catheter/every shift**	**90**	**XXX.XX**
0111111110	**123456789X**	**E1399**					**31**	**Trach tube holder – every 3 days**	**10**	**XXX.XX**
0111111110	**123456789X**	**E1399**					**31**	**Compressor**	**30**	**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	**XXXX.XX**

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

ATTACHMENT 6
Prior Authorization Amendment Request Completion Instructions

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

FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

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

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

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

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

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

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

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

SECTION I — MEMBER INFORMATION

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

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

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

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

SECTION II — PROVIDER INFORMATION

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

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

SECTION III — AMENDMENT INFORMATION

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

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

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

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

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

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

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

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

ATTACHMENT 7
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

ATTACHMENT 8
Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions

(A copy of the "Prior Authorization/Durable Medical Equipment Attachment [PA/DMEA] Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA) COMPLETION INSTRUCTIONS

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

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

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

Instructions: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested equipment or supplies. If the space provided is not sufficient, attach additional pages for the provider's responses and/or an occupational or physical therapy report if available. All DME, including repairs, must be prescribed by a physician. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Attach a photocopy of the physician's prescription to the completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), F-11030. The prescription must be signed and dated within six months of receipt by ForwardHealth. Attach the PA/DMEA 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

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

SECTION I — MEMBER INFORMATION

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

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

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

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 5 — Prescribing Physician's National Provider Identifier
Enter the National Provider Identifier (NPI) of the prescribing physician. The NPI in this element must correspond with the provider name listed in Element 4.

Element 6 — Telephone Number — Prescribing Physician
Enter the prescribing physician's telephone number, including area code.

Element 7 — Telephone Number — Dispensing Provider
Enter the dispensing provider's telephone number, including area code.

SECTION III — SERVICE INFORMATION

Element 8
Describe the overall physical status of the member (mobility, self-care, strength, coordination).

Element 9
Describe the medical condition of the member as it relates to the equipment/item requested. Indicate why the member needs this equipment.

Element 10
Indicate if the member is able to operate the equipment/item requested.

Element 11
Indicate if training is provided or required.

Element 12
State where equipment/item will be used. Describe type of dwelling and accessibility.

Element 13
State estimated duration of need.

Element 14
If renewal or continuation of DME authorization is requested, describe the following about the member, including current clinical condition, progress (improvement, no change, etc.), results, and the member's use of equipment/item prescribed.

Element 15
Indicate amount of oxygen to be administered.

Element 16 — Signature — Requesting Provider
Enter the signature of the requesting provider.

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

Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by ForwardHealth.

ATTACHMENT 9
Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) (for photocopying)

(A copy of the "Prior Authorization/Durable Medical Equipment Attachment [PA/DMEA]" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11030 (10/08)

STATE OF WISCONSIN
HFS 107.24(3), Wis. Admin. Code
HFS 152.06(3)(h), HFS 153.06(3)(g), HFS 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions, F-11030A.

SECTION I — MEMBER INFORMATION

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

3. Member Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Prescribing Physician	5. Prescribing Physician's National Provider Identifier
6. Telephone Number — Prescribing Physician	**7. Telephone Number — Dispensing Provider**

SECTION III — SERVICE INFORMATION

8. Describe the overall physical status of the member (mobility, self-care, strength, coordination).

9. Describe the medical condition of the member as it relates to the equipment / item requested (e.g., describe why the member needs this equipment).

Continued

SECTION III — SERVICE INFORMATION (continued)

10. Is the member able to operate the equipment / item requested?

❑ Yes ❑ No — If not, who will do this?

11. Is training provided or required?

❑ Yes ❑ No — If not, who will do this?

Explain.

12. State where equipment / item will be used.

❑ Home ❑ Office
❑ Nursing Home ❑ Job
❑ School

Describe type of dwelling and accessibility.

13. State estimated duration of need.

14. If renewal or continuation of DME authorization is requested, describe the following about the member, including current clinical condition, progress (improvement, no change, etc.), results, and the member's use of equipment / item prescribed.

15. Indicate amount of oxygen to be administered.

____ Liters per minute ____ Continuous
____ Hours per day ____ PRN
____ Days per week ____ PaO_2

Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by ForwardHealth.

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

ATTACHMENT 10
Prior Authorization/Oxygen Attachment (PA/OA) Completion Instructions

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

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FORWARDHEALTH
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA) COMPLETION INSTRUCTIONS

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

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

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

Instructions: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested oxygen-related equipment or supplies. All oxygen-related services must be prescribed by a physician prior to providing the service. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Providers may attach a photocopy of the physician's prescription to the completed Prior Authorization/Oxygen Attachment (PA/OA), F-11066, or the prescribing physician may sign and date the PA/OA in lieu of attaching the prescription. The prescription (or PA/OA) must be signed and dated within 30 days prior to receipt by ForwardHealth. Attach the PA/OA to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers are required to attach a completed Record of Actual Daily Oxygen Use form, F-11067, or a copy of the member's oxygen use records to the PA/OA for members who reside in a nursing home.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

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

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

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Medical Equipment Vendor
Enter the name of the medical equipment vendor (oxygen provider).

Element 2 — Medical Equipment Vendor's National Provider Identifier (NPI)
Enter the NPI of the medical equipment vendor (oxygen provider). The NPI in this element must correspond with the provider name listed in Element 1.

Element 3 — Telephone Number — Medical Equipment Vendor
Enter the medical equipment vendor's telephone number, including area code.

Element 4 — Requested Start Date
Enter the requested grant date for this PA request in MM/DD/CCYY format.

Element 5 — Name — Person Completing Form
Enter the name of the person completing this form if other than the treating physician.

Element 6 —Title — Person Completing Form
Enter the title of the person completing this form if other than the treating physician (e.g., respiratory therapist, home health nurse, billing manager).

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 8 — Prescribing Physician's NPI
Enter the NPI of the prescribing physician. The NPI in this element must correspond with the provider name listed in Element 7.

Element 9 — Address — Prescribing Physician
Enter the complete address (street, city, state, and ZIP+4 code) of the prescribing physician.

Element 10 — Telephone Number — Prescribing Physician
Enter the prescribing physician's telephone number, including area code.

SECTION II — MEMBER INFORMATION

Element 11 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or the spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 12 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 13 — Height and Weight — Member
Enter the member's height in inches and weight in pounds. This field is optional unless height and weight are related to respiratory diagnosis.

Element 14 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 15 — Place of Service
Select the appropriate place of service code. If place of service code "31" (Skilled nursing facility) or "32" (nursing facility) are selected, complete Element 16.

Element 16 — Name and Address — Facility (if applicable)
Enter the name and address of the nursing facility in which the member resides, if applicable.

SECTION III — CLINICAL INFORMATION

Element 17 — Estimated Length of Need
Enter the estimated time (in months) that the member will require oxygen. If the physician expects that the member will require the item for the duration of his or her life, then enter "99."

Element 18 — Diagnosis — Codes and Descriptions
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes and descriptions most relevant to the oxygen-related services requested.

Note: Medical equipment vendors may choose to provide only a written description.

Element 19 — Qualifying Test
Enter the results of the qualifying test taken within 60 days prior to the date of submission or requested start date of the PA request. The criteria for coverage of oxygen-related services include one or both of the following:
Oxygen saturation level (SAO_2) of 88 percent or lower.
Arterial blood gas level (PO_2) of 55 mm/Hg or lower.

Test results must have been taken within 60 days prior to the date of submission or the requested start date. Test results are to be available in the member's record or case file.

Element 20
Enter the oxygen liter flow rate/number of hours per day prescribed by a physician. If not used on a scheduled basis, describe circumstances and frequency of use.

Element 21 — Type of Oxygen Prescribed
Indicate the type of oxygen requested.

Element 22 — Means of Delivery Prescribed
Indicate the means of delivery of the oxygen.

Element 23
Answer questions a-c about portable oxygen and member mobility information.

Element 24
If the member's arterial blood gas level (PO_2) is 56 mm/Hg or above or the member's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

Element 25
Describe the medical condition of the member that supports the use of oxygen (e.g., describe why the member needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

Element 26 — Date of Prescription
Enter the date of the physician's prescription in MM/DD/CCYY format.

Element 27 — Prescription as Written
Enter the physician's prescription as it is written. If the prescribing physician signs the PA/OA, ForwardHealth will accept it in lieu of the physician's written prescription, and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of receipt by ForwardHealth or the requested start date of the PA request.

Element 28 — SIGNATURE — Prescribing Physician
The original signature of the provider prescribing the oxygen-related services must appear in this element, or the physician's prescription must be attached to the PA request.

Element 29 — Date Signed
Enter the month, day, and year the PA/OA was signed in MM/DD/CCYY format.

ATTACHMENT 11
Prior Authorization/Oxygen Attachment (PA/OA) (for photocopying)

(A copy of the "Prior Authorization/Oxygen Attachment (PA/OA)" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA)

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Oxygen Attachment (PA/OA) Completion Instructions, F-11066A. Providers are required to attach a completed Record of Actual Daily Oxygen Use form, F-11067, or a copy of the member's oxygen use records to the PA/OA for members who reside in a nursing home.

SECTION I — PROVIDER INFORMATION

1. Name — Medical Equipment Vendor	2. Medical Equipment Vendor's National Provider Identifier (NPI)
3. Telephone Number — Medical Equipment Vendor	4. Requested Start Date
5. Name — Person Completing Form	6. Title — Person Completing Form
7. Name — Prescribing Physician	8. Prescribing Physician's NPI
9. Address — Prescribing Physician (Street, City, State, and ZIP+4 Code)	10. Telephone Number — Prescribing Physician

SECTION II — MEMBER INFORMATION

11. Name — Member (Last, First, Middle Initial)	12. Member Identification Number
13. Height and Weight — Member Height _____ inches Weight _____ lbs	14. Date of Birth — Member
15. Place of Service (choose one) ❑ 11 = Office ❑ 12 = Home ❑ 31 = Skilled Nursing Facility ❑ 32 = Nursing Facility ❑ 99 = Other Place of Service	16. Name and Address — Facility (if applicable)

SECTION III — CLINICAL INFORMATION

17. Estimated Length of Need (1-98 months; 99 = Lifetime) _____ months	18. Diagnosis — Codes and Descriptions Primary — Secondary —

19. Qualifying Test — Enter results of test taken within 60 days prior to the date of submission or requested start date of the PA request. Test results are to be available in the member's record or case file. **Note: Criteria for coverage of oxygen-related services include either an oxygen saturation level (SAO_2) of 88 percent or lower or an arterial blood gas level (PO_2) of 55 mm/Hg or lower at rest.**

a) Date _____/_____/_____ b) Member condition during test (choose one) ❑ At rest ❑ During exercise ❑ During sleep c) Arterial blood gas level (PO_2) _____ mm/Hg d) Oxygen saturation level (SAO_2) _____ %	e) Name, Address, and Credentials — Provider Performing Qualifying Test

Continued

SECTION III — CLINICAL INFORMATION (cont.)

20. Enter the oxygen liter flow rate / number of hours per day as prescribed by the physician.

    a) _____ Liters per minute

    b) _____ Hours per day

    c) _____ Days per week

    d) _____ Continuous

    e) _____ PRN, describe circumstances and frequency of use —

21. Type of Oxygen Prescribed	22. Means of Delivery Prescribed
❑ Concentrator	❑ Nasal Cannula
❑ Liquid	❑ Mask
❑ Gaseous	❑ Other (Specify) _____

23. Indicate portable oxygen and member mobility information, if applicable.

    a) Is portable oxygen prescribed? ❑ Yes ❑ No ❑ N/A

    b) If portable oxygen is prescribed, is the member mobile? ❑ Yes ❑ No ❑ N/A

    c) If the member is mobile and portable oxygen is prescribed, describe to what extent the member is mobile.

24. If the member's arterial blood gas level (PO_2) is 56 mm/Hg or above or the member's oxygen saturation level (SAO_2) is 89 percent or above at rest, answer questions a-d.

    a) Does member have clinical evidence of chronic or recurrent congestive heart failure? ❑ Yes ❑ No ❑ N/A

    b) Does member have cor pulmonale or pulmonary hypertension documented by P pulmonale on an electrocardiogram or by an echocardiogram, gated blood pool scan, or direct pulmonary artery pressure measurement? ❑ Yes ❑ No ❑ N/A

    c) Does member have clinical evidence of decubital angina? ❑ Yes ❑ No ❑ N/A

    d) Does member have erythrocythemia with a hematocrit greater than 56 percent? ❑ Yes ❑ No ❑ N/A

25. Describe the medical condition of the member that supports the use of oxygen (e.g., describe why the member needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

26. Date of Prescription (MM/DD/CCYY)

27. Prescription as Written

If the prescribing physician signs the PA/OA, ForwardHealth will accept it in lieu of the physician's written prescription, and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of receipt by ForwardHealth or the requested start date of the PA request.

28. **SIGNATURE** — Prescribing Physician	29. Date Signed

ATTACHMENT 12
Record of Actual Daily Oxygen Use Completion Instructions

(A copy of the "Record of Actual Daily Oxygen Use Completion Instructions" is located on the following page.)

FORWARDHEALTH
RECORD OF ACTUAL DAILY OXYGEN USE COMPLETION INSTRUCTIONS

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

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

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

The use of this form is mandatory when requesting prior authorization for certain services.

Instructions: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested oxygen-related equipment or supplies. All oxygen-related services must be prescribed by a physician prior to providing the service. Information on this form must match the member's medical records exactly. A new form should be completed for each new PA request for oxygen-related services. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Providers are required to attach a completed Record of Actual Daily Oxygen Use form, F-11067, or a copy of the member's oxygen use records to the PA/OA for members who reside in a nursing home. Providers may attach a photocopy of the physician's prescription to the completed Prior Authorization/Oxygen Attachment (PA/OA), F-11066, or the prescribing physician may sign and date the PA/OA in lieu of attaching the prescription. The prescription (or PA/OA) must be signed and dated within 30 days prior to receipt by ForwardHealth. Attach the PA/OA 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 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 — PROVIDER INFORMATION

Element 1 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 2 — National Provider Identifier
Enter the National Provider Identifier (NPI) of the prescribing physician. The NPI in this element must correspond with the provider name listed in Element 1.

SECTION II — MEMBER INFORMATION

Element 3 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or the 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.

SECTION III — RECORD OF DAILY USE

Element 5 — Complete the date oxygen was initiated in MM/DD/CCYY format. This date is "Day 1." Place an "X" in each shift for each day that the member actually received oxygen. The member must receive oxygen for at least 15 days of a 30-day rental period for a PA request to be considered for approval. The oxygen need not be administered for the whole shift. Leave blank any shifts during which oxygen was not administered.

ATTACHMENT 13
Record of Actual Daily Oxygen Use
(for photocopying)

(A copy of the "Record of Actual Daily Oxygen Use" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11067 (10/08)

STATE OF WISCONSIN
HFS 107.24(3), Wis. Admin. Code

FORWARDHEALTH

RECORD OF ACTUAL DAILY OXYGEN USE

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Record of Actual Daily Oxygen Use Completion Instructions, F-11067A.

SECTION I — PROVIDER INFORMATION

1. Name — Prescribing Physician	2. National Provider Identifier

SECTION II — MEMBER INFORMATION

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

SECTION III — RECORD OF DAILY USE

5. Complete the date oxygen was initiated in MM/DD/CCYY format. This date is "Day 1." _____ / _____ / _____

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
AM							
PM							
NOC							
	DAY 8	DAY 9	DAY 10	DAY 11	DAY 12	DAY 13	DAY 14
AM							
PM							
NOC							
	DAY 15	DAY 16	DAY 17	DAY 18	DAY 19	DAY 20	DAY 21
AM							
PM							
NOC							
	DAY 22	DAY 23	DAY 24	DAY 25	DAY 26	DAY 27	DAY 28
AM							
PM							
NOC							
	DAY 29	DAY 30	DAY 31				
AM							
PM							
NOC							

ATTACHMENT 14
STAT-PA System Instructions

(A copy of the "STAT-PA System Instructions" is located on the following pages.)

(This page was intentionally left blank.)

FORWARDHEALTH
STAT-PA SYSTEM INSTRUCTIONS

The ForwardHealth Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system is an automated voice response system that allows Medicaid-certified providers to receive PA via telephone rather than by mail or the Web. Providers answer a series of questions and receive an immediate response of an approved or returned PA.

Providers communicate with the STAT-PA system by entering requested information on a touch-tone telephone keypad or by calling Provider Services. Providers must have their provider number to access the STAT-PA system.

The STAT-PA system is available by calling one of the following telephone numbers:

- **Touch-Tone Telephone**
  (800) 947-1197
  Available 24 hours a day, seven days a week.
- **Provider Services**
  (800) 947-9627
  Available from 7:00 a.m. to 6:00 p.m., Monday through Friday, excluding state-observed holidays.

REQUIRED INFORMATION

All providers using STAT-PA are required to provide the following information:

- Provider number.
- Practice Location ZIP+4 code.
- Member identification number.
- National Drug Code (NDC) or procedure code.
- *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code.
- Patient location.
- First date of service (DOS).
- Days supply or total number requested.

Note: When requesting a drug, Prescribing Provider information is required. Additionally, if a National Provider Identifier (NPI) is entered, and the requesting provider is not a retail pharmacy, the Taxonomy Code is required.

HOW TO USE WISCONSIN STAT-PA

1. Complete the appropriate PA attachment form.
2. Select mode of transmission (touch-tone telephone or Provider Services).

TOUCH-TONE TELEPHONE REQUESTS

To use a touch-tone telephone to submit a PA request:

1. Call (800) 947-1197. This connects the provider directly with the STAT-PA system.
2. When the system answers, it will ask a series of questions that providers answer by entering the information on the telephone keypad. The service-specific PA attachments list the information needed in the order it is requested by the STAT-PA system.

Note: When using a touch-tone telephone to enter the NPI, member ID, NDC or procedure code, ICD-9-CM diagnosis code, patient location code, requested first DOS, and quantity, always press the pound (#) key to mark the end of the data just entered. The pound (#) key signals the system that the provider has finished entering the data requested and ensures the quickest response from the system.

Providers may be asked to enter alphabetic data, which can be entered by using the asterisk (*) key. For example, a provider is asked to enter a procedure code such as L3216. The first character is an alpha character; therefore, the provider presses the single asterisk (*) key followed by the two digits that indicate the letter. The first digit is the number on the keypad where the letter is located, and the second digit is the position of the letter on that key. For example: Procedure code L3216 should be entered as *53 3 2 1 6.

Alphabet Key:

A = *21	G = *41	M = *61	S = *73	Y = *93
B = *22	H = *42	N = *62	T = *81	Z = *12
C = *23	I = *43	O = *63	U = *82	
D = *31	J = *51	P = *71	V = *83	
E = *32	K = *52	Q = *11	W = *91	
F = *33	L = *53	R = *72	X = *92	

3. Once all data have been entered completely, STAT-PA processes the information, indicates the status of the PA request, and gives providers the chance to finalize, cancel, or change their entered information. Once the PA request is finalized, STAT-PA indicates the PA number and, if approved, the effective dates and authorized number of services.

Once familiar with the STAT-PA system, providers may enter the PA information in the designated order immediately — there is no need to wait for the full voice prompt. Providers may key information at any time, even when the system is processing information. The system automatically proceeds to the next function.

PROVIDER SERVICES REQUESTS

Providers who do not have a touch-tone telephone may call Provider Services at (800) 947-9627. The Provider Services correspondent will access STAT-PA and enter the required data requested from the provider.

Provider Services is available to all STAT-PA users. Providers who are experiencing difficulties with the system can select to be transferred to Provider Services for assistance.

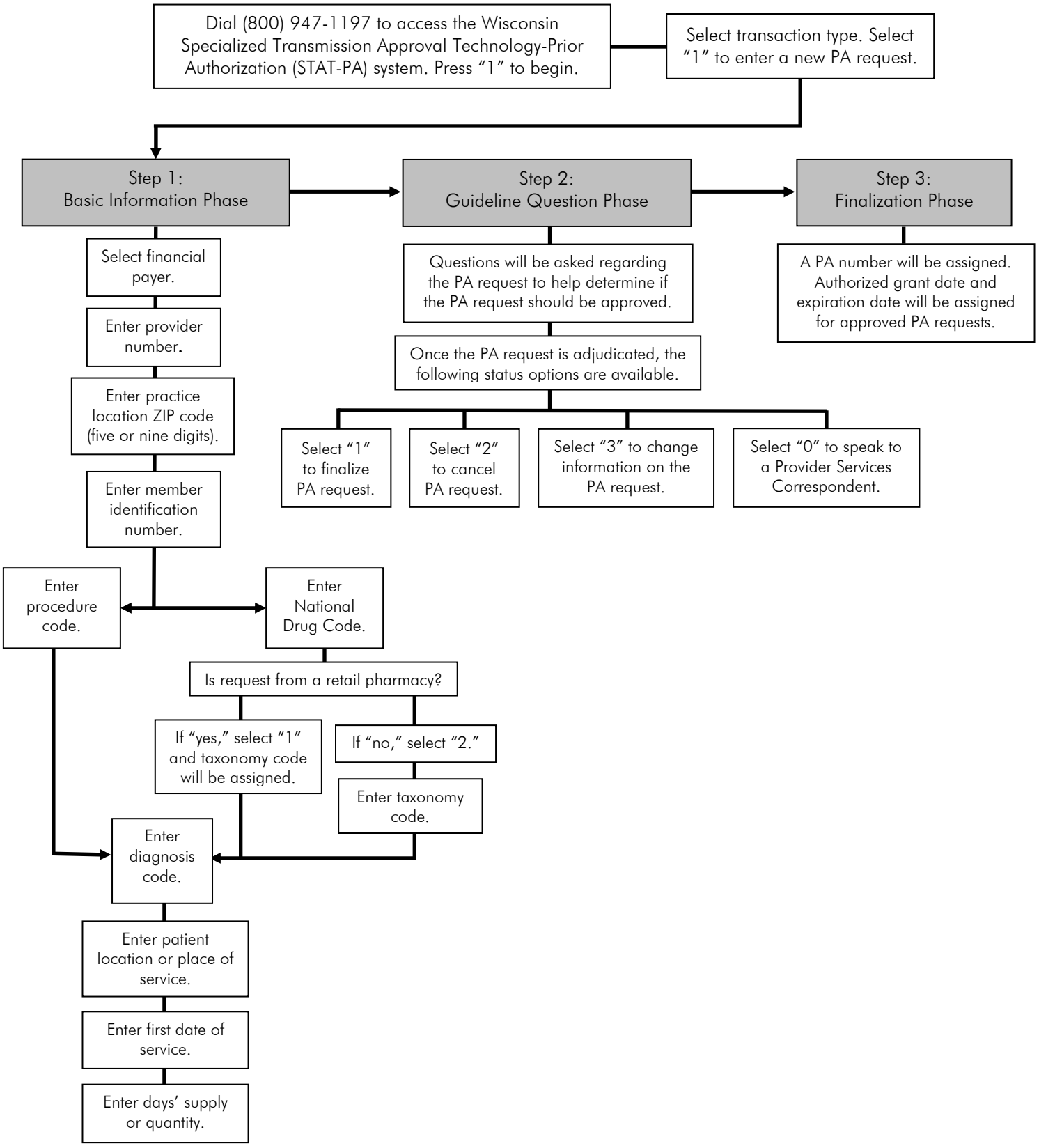
DOCUMENTATION INFORMATION

Providers must maintain all documentation that supports medical necessity, claim information, and delivery of the approved service(s) in their records for a period not less than five years. Regardless of what STAT-PA method is used, providers will receive a letter by mail indicating the assigned PA number and the STAT-PA decision. Providers with a secure ForwardHealth Portal account will also receive a copy of this letter in their portal mailbox. This letter should be maintained as a permanent record of the transaction.

Helpful Hints

- The provider is given three attempts at each field to correctly enter the requested data. If those attempts are unsuccessful, the provider can select to be transferred to Provider Services for assistance, or the call will be terminated.
- Providers are given two attempts to enter data within 10 seconds. If those attempts are unsuccessful, the provider can select to be transferred to Provider Services for assistance, or the call will be terminated.
- Providers are allowed 25 PA requests per connection for touch-tone telephone.
- Providers are allowed up to 25 minutes per connection for touch-tone telephone.
- The decimal point for diagnosis codes is not required when entering a STAT-PA request by touch-tone telephone; however, all digits of the codes must be entered.
- The first date of service entered by the provider may be up to 31 calendar days in the future or up to 14 days in the past.
- Providers who need to end date a PA request due to a change in prescription may do so through STAT-PA if the request was originally submitted through STAT-PA. If a provider needs assistance with the end date process, the provider may select to be transferred to Provider Services for assistance.

ATTACHMENT 15
STAT-PA Quick Reference Guide



ATTACHMENT 16
STAT-PA Orthopedic Shoes Worksheet Completion Instructions

(A copy of the "STAT-PA Orthopedic Shoes Worksheet Completion Instructions" is located on the following pages.)

FORWARDHEALTH
STAT-PA ORTHOPEDIC SHOES WORKSHEET INSTRUCTIONS

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

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

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

The use of this form is mandatory when requesting PA for certain items. 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. Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

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

Element 3 — 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 II — PROVIDER INFORMATION

Element 4 — Provider Name
Enter the name of the provider.

Element 5 — National Provider Identifier
Enter the National Provider Identifier.

SECTION III — CLINICAL INFORMATION FOR ORTHOPEDIC SHOES

Element 6 — Prescription Signature Date
Enter the date the prescription was signed.

Element 7
Check the appropriate box to indicate whether or not the member has received orthopedic shoes in the past. If "yes," proceed to the next question. If "no," proceed to Element 15.

Element 8
Check the appropriate box to indicate whether or not the member wore orthopedic shoes to the pedorthic examination. If "yes," proceed to the next question. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

Element 9
Check the appropriate box to indicate whether or not the member's current shoes are in disrepair. If "yes," proceed to the next question. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

Element 10
Check the appropriate box to indicate whether or not the requested shoes are manufactured by Drew, P.W. Minor, Markell, or Apex. If yes, proceed to the next question. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

Element 11 — Mobility Level
Enter the Mobility Level that best describes the member (either "1," "2," or "3").

Element 12 — Diagnosis Level
Enter the Diagnosis Level that best describes the member (either "1," "2," "3," or "4").

Element 13 — Need Level Number
Enter the member's nine-digit Need Level (NDL) number. (Use a "1" to indicate "yes" or a "2" to indicate "no.")

SECTION IV — FOR PROVIDERS USING STAT-PA

Element 14 — Procedure Code of Product Requested
Enter **one** requested procedure code per STAT-PA request. For touch-tone telephone users, the code will be entered as follows:
L3216 = *53 3 2 1 6 L3221 = *53 3 2 2 1 A5500 = *21 5 5 0 0

Element 15 — Diagnosis Code
Use the most appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code. For STAT-PA, the decimal is not necessary; however, all digits of the code must be entered.

Element 16 — Place of Service
Enter the appropriate place of service code designating where the requested product would be provided.

Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
20	Urgent Care Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic

Element 17 — Requested First Date of Service
Enter the requested first date of service (DOS) for the product. For STAT-PA, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 18 — Total Number Requested
Enter the total number of products being requested.

Element 19 — Assigned Prior Authorization Number
Record the PA number assigned by the STAT-PA system.

Element 20 — Grant Date
Record the grant date of the PA as assigned by the STAT-PA system.

Element 21 — Expiration Date
Record the date that the PA expires as assigned by the STAT-PA system.

SECTION V — SIGNATURE

Element 22 — SIGNATURE — Provider
The provider must sign this element.

Element 23 — Date Signed
Enter the date signed in MM/DD/CCYY format.

SECTION VI — ADDITIONAL INFORMATION

Element 24
Indicate any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 17
STAT-PA Orthopedic Shoes Worksheet (for photocopying)

(A copy of the "STAT-PA for Orthopedic Shoes Worksheet" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11052 (10/08)

STATE OF WISCONSIN
HFS 107.24(3), Wis. Admin. Code

FORWARDHEALTH

STAT-PA ORTHOPEDIC SHOES WORKSHEET

Instructions: Type or print clearly. Before completing this form, read the STAT-PA Orthopedic Shoes Worksheet Instructions, F-11052A. Refer to the STAT-PA System Instructions, F-11055, for details regarding data entry through the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system.

The provider is required to enter all information for each category in the spaces provided. The STAT-PA system will ask for the following information in the order listed below.

SECTION I — MEMBER INFORMATION

1. Name — Member	2. Date of Birth — Member
3. Member Identification Number	

SECTION II — PROVIDER INFORMATION

4. Provider Name	5. National Provider Identifier

SECTION III — CLINICAL INFORMATION FOR ORTHOPEDIC SHOES

All information must be entered for each category, both in the STAT-PA system and on this worksheet.

6. Prescription Signature Date

7. Has the member received orthopedic shoes in the past? If no, proceed to Element 10.	❑ Yes	❑ No
8. Did the member wear orthopedic shoes to the pedorthic examination?	❑ Yes	❑ No
9. Are the member's current shoes in disrepair?	❑ Yes	❑ No
10. Are the requested shoes manufactured by Drew, P.W. Minor, Markell, or Apex?	❑ Yes	❑ No

11. Enter the Mobility Level (MBL) that best describes the member. ____
MBL 1 — The member walks in the community with or without the assistance of another person or an assistive device.
MBL 2 — The member walks only in his or her place of residence with or without the assistance of another person or an assistive device.
MBL 3 — The member does not stand up to walk or transfer without maximum assistance or mechanical support .

12. Enter the Diagnosis Level (DXL) that best describes the member. ____
DXL 1 — The member has urinary incontinence or any underlying pathology that results in a flat foot.
DXL 2 — The member has diabetes with complications such as: gross foot deformity (excluding ICD-9-CM diagnosis code 250.0), history of foot ulcers, or loss of sensation.
DXL 3 — The member has gross foot deformity(ies).
DXL 4 — The member has a chronic disorder or disability, without gross foot deformity, such as: osteoarthritis, rheumatoid arthritis, cerebral palsy, mental retardation, cerebral vascular accident, peripheral vascular disease, cardiovascular disease, diabetes without complications, plantar fasciitis, Alzheimer's disease, senile dementia, multiple sclerosis, or Parkinson's disease.

13. Enter the member's nine-digit Need Level (NDL) number. ____ ____ ____ ____ ____ ____ ____ ____ ____

NDL 1 — Are the extra depth shoes necessary for arch supports to treat flat feet?	❑ Yes (1)	❑ No (2)
NDL 2 — Do extra depth shoes require replacement due to soiling from urine?	❑ Yes (1)	❑ No (2)
NDL 3 — Are extra depth shoes necessary to accommodate shoe inserts that will support an orthopedic deformity (other than those in NDL 1)?	❑ Yes (1)	❑ No (2)
NDL 4 — Are extra depth shoes necessary to accommodate AFO/KAFO (other than those in NDL 1)?	❑ Yes (1)	❑ No (2)
NDL 5 — Does the member have a leg length discrepancy equal to or greater than ½ inch?	❑ Yes (1)	❑ No (2)
NDL 6 — Are extra depth shoes necessary to provide support for the member's gross foot deformity?	❑ Yes (1)	❑ No (2)
NDL 7 — Will the member maintain his or her MBL if orthopedic shoes are provided?	❑ Yes (1)	❑ No (2)
NDL 8 — Can the member improve at least one full MBL if orthopedic shoes are provided?	❑ Yes (1)	❑ No (2)
NDL 9 — Are mismate shoes equal to, or greater than, one full size necessary?	❑ Yes (1)	❑ No (2)

SECTION IV — FOR PROVIDERS USING STAT-PA

14. Procedure Code of Product Requested	15. Diagnosis Code	
16. Place of Service	17. Date of Service	18. Total Number Requested
19. Assigned Prior Authorization Number	20. Grant Date	21. Expiration Date

SECTION V — SIGNATURE

22. **SIGNATURE** — Provider	23. Date Signed

SECTION VI — ADDITIONAL INFORMATION

24. Include any additional information in the space below. Submit additional information on a separate sheet if necessary.