ForwardHealth
Wisconsin serving you

Update
March 2010

No. 2010-18

Affected Programs: BadgerCare Plus, Medicaid
To: Home Health Providers, HMOs and Other Managed Care Organizations

Renamed and Revised Forms and Instructions for Home Health Services

This *ForwardHealth Update* introduces the Prior Authorization/Care Plan Attachment (PA/CPA), F-11096 (03/10), to replace the Prior Authorization/Home Care Attachment (PA/HCA), F-11096 (10/08), as a result of an initiative relating to private duty nursing (PDN) services. The changes to the form and the form instructions affect requesting prior authorization (PA) and the documentation requirements for plans of care (POC).

The PA/CPA completion instructions apply to PA requests for home health skilled nursing and home health aide services for dates of service (DOS) on and after May 1, 2010. The required information for the PA/CPA is required for POCs for home health skilled nursing and home health aide services for DOS on and after July 1, 2010.

Additionally, the completion instructions for the Prior Authorization/Request Form (PA/RF) and the UB-04 claim form are revised for home health services effective for DOS on and after May 1, 2010.

Overview of Form and Completion Instruction Changes for Home Health Skilled Nursing and Aide Services

This *ForwardHealth Update* introduces the Prior Authorization/Care Plan Attachment (PA/CPA), F-11096 (03/10), to replace the Prior Authorization/Home Care Attachment (PA/HCA), F-11096 (10/08), as a result of an initiative relating to private duty nursing (PDN) services. The changes to the form and the form completion instructions affect requesting prior authorization (PA) and the documentation requirements for plans of care (POC).

Additionally, the completion instructions for the Prior Authorization Request Form (PA/RF), F-11018 (10/08), and the UB-04 Claim Form are revised for home health services effective for dates of service (DOS) on and after May 1, 2010.

Prior Authorization/Care Plan Attachment

The PA/CPA is replacing the PA/HCA for home health services for DOS on and after May 1, 2010, to accommodate changes to PA for PDN services. Although the use of the PA/CPA form is voluntary and providers may use their own formats for POC, the requested information in the PA/CPA is required information to be included in provider-created POC.

Prior Authorization/Request Form Instructions Revised

Providers are required to use the revised PA/RF completion instructions effective for DOS on and after May 1, 2010, for home health services. For home health services, the changes to the PA/RF instructions include, but are not limited to, the following:

- The introduction.
- Element 8 — Address – Member.
- Element 21 — Description of Service.

Refer to Attachment 1 of this *Update* for the revised PA/RF completion instructions for home health services.

Plans of Care for Home Health Skilled Nursing and Home Health Aide Services

Plans of Care for Services Provided Between May 1, 2010 and June 30, 2010

All POC for home health skilled nursing and for home health aide services provided between May 1, 2010, and June 30, 2010, must contain no less information than is required for one of the following documents:

- Prior Authorization/Home Care Attachment, F-11096 (10/08).
- Prior Authorization/Care Plan Attachment, F-11096 (03/10).

Plans of Care for Services Provided on and After July 1, 2010

All POC for home health skilled nursing and for home health aide services provided on and after July 1, 2010, must contain no less information than is required for the PA/CPA.

Requesting Prior Authorization for Home Health Skilled Nursing and Home Health Aide Services for Dates of Service on and After May 1, 2010

Providers are required to include in the POC no less information than is required on the PA/CPA when requesting PA for home health skilled nursing and for home health aide services for DOS requested to begin on and after May 1, 2010. Requests for PA submitted on the wrong forms or completed using the wrong completion instructions will be returned to the provider unprocessed.

Form and Completion Instruction Revisions

Providers are strongly encouraged to familiarize themselves with the PA/CPA form and completion instructions. Changes to the PA/CPA form and completion instructions include, but are not limited to the following:

- Element 4 — Certification Period.
- Element 15 — Orders for Services and Treatments.
- Element 23 — Names of Other Providers with Whom This Case Is Shared.
- Section VI — Signatures.

Refer to Attachments 2 and 3 for the PA/CPA completion instructions form.

Portal Prior Authorization

The PA/CPA is available electronically on the Forms page of the Providers area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/*. The PA/CPA form will be available for Portal-submitted PAs beginning on May 1, 2010.

Claim Form Instructions Revised

Providers are strongly encouraged to familiarize themselves with the UB-04 claim form instructions used with home health claims submitted to ForwardHealth on and after May 1, 2010. Changes to the UB-04 claim form instructions include, but are not limited to, the instructions for the following:

- Form Locator 46 — Serv. Units.
- Form Locator 76 — Attending.

Refer to Attachment 4 for the UB-04 claim form completion instructions for home health services effective for claims submitted to ForwardHealth on and after May 1, 2010.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

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

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

P-1250

ATTACHMENT 1
Prior Authorization/Request Form (PA/RF) Completion Instructions for Home Health Services

Effective for dates of service on and after May 1, 2010.

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 (DHS 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. Failure to supply the information requested by the form instructions may result in denial of PA or payment for the service.

Providers should retain copies of all documents submitted to ForwardHealth. Providers may submit PA requests, along with the plan of care (POC) containing no less information than is required for the Prior Authorization/ Care Plan Attachment (PA/CPA), F-11096, for home health skilled nursing and home health aide services or the Prior Authorization/Home Health Therapy Attachment (PA/HHTA), F-11044 (10/08), for home health therapy services via the ForwardHealth Portal at *www/forwardhealth.wi.gov/*, by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

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

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

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck "Other Services." Enter an "X" in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter process type "120" for home health services. The process type is used to identify a category of service requested. Prior authorization requests will be returned if a process type is not indicated.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

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

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

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

SECTION II — MEMBER INFORMATION

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

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

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code.

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

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

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

Element 12 — Start Date — SOI (not required)

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

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

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

Element 16 — Rendering Provider Number (not required)

Element 17 — Rendering Provider Taxonomy Code (not required)

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

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

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

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

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

If sharing a case with another provider, enter "shared case."

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

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

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

Element 24 — Total Charges
Enter the anticipated total charges for this request. If the provider completed a multiple page PA/RF, indicate the total charges for the entire PA request in Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 must refer to the last page (for example, "SEE PAGE TWO").

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing this service/procedure 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 2
Prior Authorization/Care Plan Attachment (PA/CPA) Completion Instructions

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

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FORWARDHEALTH
PRIOR AUTHORIZATION / CARE PLAN ATTACHMENT (PA/CPA) 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 (DHS 104.02[4], Wis. Admin. Code).

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

The Prior Authorization/Care Plan Attachment (PA/CPA), F-11096, is the plan of care (POC) that is required to be completed for ForwardHealth members receiving private duty nursing (PDN), home health, and pediatric community care (PCC) services. The information requested in each element of the PA/CPA is required information to be included in the POC; however, the use of the form is voluntary. Attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

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

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

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

SECTION I — MEMBER INFORMATION

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

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

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

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

Element 4 — Certification Period
Enter the beginning and ending dates of the certification period respectively in the "From" and "To" portions of this element in MM/DD/CCYY format. The certification period identifies the period of time the attending physician orders services to be provided.

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

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

Example:

Initial Certification Period	
"From" date	05/01/2010
"To" date	07/01/2010

Subsequent Recertification Period	
"From" date	07/02/2010
"To" date	09/01/2010

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

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

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

Enter all other diagnoses pertinent to the care rendered for the member. Include the appropriate narrative or ICD-9-CM diagnosis code, code description, and the date of onset in MM/DD/CCYY format. Include all conditions that coexisted at the beginning of the certification period or that subsequently developed. Exclude conditions that relate to an earlier episode. Other pertinent diagnoses in this element may be changed to reflect changes in the member's condition.

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

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

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

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

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

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

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

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

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

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

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

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

SECTION IV — ORDERS

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

- Number of member visits (e.g., home health skilled nursing, home health aide, or medication management), frequency of visits, and duration of visits ordered by the attending physician (e.g., 1 visit, 3 times/week, for 9 weeks).
- Number of hours required for member (e.g., PDN or PCC), frequency of visits, and duration of visits ordered by the attending physician (e.g., 8 hours/day, 7 days/week, for 52 weeks).
- Duties and treatments to be performed.
- Methods for delivering care and treatments.
- Procedures to follow in the event of accidental extubation, as applicable.
- Ventilator settings and parameters, as applicable.

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

- Home health skilled nursing.
- Home health aide.
- Private duty nursing.
- Pediatric community care.

Orders must include all disciplines providing services for the member and all treatments the member receives regardless of whether or not the services are reimbursable by Wisconsin Medicaid or BadgerCare Plus. Orders should be as detailed and specific as those ordered and written by the attending physician.

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

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

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

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

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

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

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

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

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

Element 20 — Current Information
For initial certification periods, enter the clinical findings of the initial assessment visit for each involved discipline. Describe the clinical facts about the member that require PDN, personal care (PC), home health, and PCC services and include specific dates in MM/DD/CCYY format.

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

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

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

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

Element 23 — Names of Other Providers with Whom This Case Is Shared
This element is required for all providers who case share with other providers providing PDN, PC, and home health services. Enter the names of other providers with whom this cased is shared.

SECTION VI — SIGNATURES

Provider-created formats must contain the following statement that is included on the PA/CPA:

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

Elements 24 and 25 — Signature and Date Signed — Authorized Registered Nurse Completing Form
The registered nurse (RN) completing the POC is required to sign and date the POC. Providers not using the PA/CPA for the POC must add the following statement to their provider-created POC. The statement must be accompanied by the authorized RN's dated signature:

"As the nurse completing this plan of care (POC), I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form."

The dated signature certifies that the nurse has received orders from the attending physician to begin providing services to the member. These elements must be completed on or before the certification period "From" date indicated in Element 4.

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

Element 27 — Date Physician-Signed Form Received
Enter the date the provider received the signed and dated POC from the attending physician.

Element 28 — Name and Address — Attending Physician
Enter the attending physician's name and complete address. The street, city, state, and ZIP+4 code must be included. The attending physician is the physician who ordered the medically necessary services.

Elements 29 and 30 — Signature and Date Signed — Attending Physician
The attending physician is required to sign and date the POC for medically necessary services within 20 working days following the initial start of care. For subsequent periods of recertification, the attending physician is required to sign and date the POC for medically necessary services prior to the provision of services.

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

"The member is under my care, and I have ordered the services on this POC."

Verbal orders may be obtained from the attending physician for the initial certification period; however, the attending physician is required to sign and date the POC within 20 working days of the start of care date.

The attending physician may not give verbal orders for subsequent certification periods. The attending physician is required to sign and date the POC prior to the provision of services to the member.

The nurse or agency staff shall not date the POC for the attending physician. If the attending physician has left Element 30 blank, the nurse or agency staff should return the POC to the physician to date and initial.

Elements 31 and 32 — Countersignature and Date Signed
When two or more providers share a PDN case, it is necessary to designate only one RN who receives orders from the attending physician to complete Element 24. *All* providers sharing the case are required to obtain a copy of the POC for the effective certification period and *countersign* and *date* Elements 31 and 32 to document that the provider has reviewed the POC and will execute it as written. Dated countersignatures required for Elements 31 and 32 must be completed before providing PDN services.

The countersignature required for Elements 31 and 32 must be completed prior to providing PDN services under this POC.

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

"As the provider countersigning this POC, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form."

ATTACHMENT 3
Prior Authorization/Care Plan Attachment (PA/CPA) (for photocopying)

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

FORWARDHEALTH

PRIOR AUTHORIZATION / CARE PLAN ATTACHMENT (PA/CPA)

Instructions: Print or type clearly. Refer to the Required Information for Prior Authorization/Care Plan Attachment (PA/CPA), Completion Instructions, F-11096A, for information about completing this form.

SECTION I — MEMBER INFORMATION

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

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (*International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment

8a. Functional Limitations			8b. If "Other" checked in Element 8a, specify other functional limitations.
1 ❑ Amputation	5 ❑ Paralysis	9 ❑ Legally Blind	
2 ❑ Bowel / Bladder (Incontinence)	6 ❑ Endurance	10 ❑ Dyspnea with Minimal Exertion	
3 ❑ Contracture	7 ❑ Ambulation	11 ❑ Other (Specify in Element 8b)	
4 ❑ Hearing	8 ❑ Speech		

9a. Activities Permitted			9b. If "Other" checked in Element 9a, specify other activities permitted.
1 ❑ Complete Bedrest	6 ❑ Partial Weight Bearing	10 ❑ Wheelchair	
2 ❑ Bedrest BRP	7 ❑ Independent at Home	11 ❑ Walker	
3 ❑ Up As Tolerated	8 ❑ Crutches	12 ❑ No Restrictions	
4 ❑ Transfer Bed / Chair	9 ❑ Cane	13 ❑ Other (Specify in Element 9b)	
5 ❑ Exercises Prescribed			

10. Medications (Dose / Frequency / Route)

11. Allergies

Continued

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION (Continued)

12. Nutritional Requirements

13. Mental Status
1 ❑ Oriented
2 ❑ Comatose
3 ❑ Forgetful
4 ❑ Depressed
5 ❑ Disoriented
6 ❑ Lethargic
7 ❑ Agitated
8 ❑ Other _____

14. Prognosis
1 ❑ Poor
2 ❑ Guarded
3 ❑ Fair
4 ❑ Good
5 ❑ Excellent

SECTION IV — ORDERS

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

Continued

SECTION IV — ORDERS (Continued)

16. Goals / Rehabilitation Potential / Discharge Plans

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

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

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

21. Home or Social Environment

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

Continued

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION (Continued)

23. Names of Other Providers with Whom This Case Is Shared

SECTION VI — SIGNATURES

Nurse Certification
As the nurse completing this plan of care (POC), I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

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

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

Physician Certification
The member is under my care, and I have ordered the services on this POC.

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

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

Case Sharing Provider
As a provider countersigning this POC, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

31. **COUNTERSIGNATURE**	32. Date Countersigned

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

ATTACHMENT 4
UB-04 (CMS 1450) Claim Form Completion Instructions for Home Health Services

Effective for claims submitted to ForwardHealth on and after May 1, 2010.

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for BadgerCare Plus. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site at *www.nubc.org/*.

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about verifying enrollment.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784--0410

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, city, state, and ZIP+4 code. The name in Form Locator 1 should correspond with the National Provider Identifier (NPI) in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on BadgerCare Plus remittance information.

Form Locator 3b — Med. Rec. # (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on BadgerCare Plus remittance information.

Form Locator 4 — Type of Bill

Enter the three-digit type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit indicates the billing frequency. Providers of home health services should use one of the following type of bill codes:

331 = Inpatient admit through discharge claim.

332 = Interim bill — first claim.

333 = Interim bill — continuing claim.

334 = Interim bill — final claim.

Form Locator 5 — Fed. Tax No.

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this form locator. If computer software does not automatically complete this form locator, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8 a-b — Patient Name

Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. 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.

Form Locator 9 a-e — Patient Address

Data are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (e.g., "On file"). If computer software does not automatically complete this form locator, enter information such as the member's complete address in field 9a.

Form Locator 10 — Birthdate

Enter the member's birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex

Specify that the member is male with a "M" or female with a "F." If a member's sex is unknown, enter "U."

Form Locator 12 — Admission Date (not required)

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src (not required)

Form Locator 16 — DHR (not required)

Form Locator 17 — Stat (not required)

Form Locators 18-28 — Condition Codes (required, if applicable)

Enter a code(s) to identifying conditions relating to this claim, if appropriate. Refer to the UB-04 Uniform Billing Manual for a list of condition codes.

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locator 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.
Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to home health services publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description
Do *not* enter any dates in this form locator.

Form Locator 44 — HCPCS/Rate/HIPPS Code
Enter the appropriate five-digit procedure code, followed by the modifiers. Modifiers may include start-of-shift modifiers and subsequent visit modifiers. No more than four modifiers per detail line may be entered. Separate the modifier(s) with commas. Refer to the Online Handbook for appropriate modifiers.

Form Locator 45 — Serv. Date
Enter the single “from” date of service (DOS) in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units
Enter the number of covered accommodations, ancillary units of service, or visits, where appropriate.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)
Enter the usual and customary charges pertaining to the related procedure code for the current billing period as entered in Form Locators 43 and 45.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field
Enter the "to" DOS in DD format. A range of consecutive dates may be indicated only if the revenue code, the procedure code (and modifiers, if applicable), the service units, and the charge were identical for each date within the range.

Detail Line 23

PAGE ___ OF ___
Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS
Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Form Locator 50 A-C — Payer Name
Enter all health insurance payers here. Enter "T19" for Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the first page of the claim.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel. Info (not required)

Form Locator 53 A-C — Asg. Ben. (not required)

Form Locator 54 A-C — Prior Payments (required, if applicable)
Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

If submitting a multiple-page claim, enter the amount paid by commercial health insurance only on the *first page* of the claim.

Form Locator 55 A-C — Est. Amount Due (not required)

Form Locator 56 — NPI
Enter the provider's NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured's Name
Data are required in this form locator for OCR processing. Any information populated by a provider's computer software is acceptable data for this form locator (e.g., "Same"). If computer software does not automatically complete this form locator, enter information such as the member's last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured's Unique ID
Enter the member's identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — Dx (not required)

Form Locator 67 — Prin. Diag. Cd.
Enter the valid, most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" (etiology) codes.

Form Locators 67A-Q — Other Diag. Codes
Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)

Form Locator 69 — Admit Dx (not required)

Form Locator 70 — Patient Reason Dx (not required)

Form Locator 71 — PPS Code (not required)

Form Locator 72 — ECI (not required)

Form Locator 73 — Unlabeled Field (not required)

Form Locator 74 — Principal Procedure Code and Date (not required)

Form Locator 74a-e — Other Procedure Code and Date (not required)

Form Locator 75 — Unlabeled Field (not required)

Form Locator 76 — Attending
Enter the attending physician's NPI. In addition, include the last and first name of the attending physician.

Form Locator 77 — Operating (not required)

Form Locators 78 and 79 — Other (not required)

Form Locator 80 — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information

Commercial health insurance coverage must be billed prior to billing ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

When the member has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to ForwardHealth for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates the provider is not Medicare certified.

  Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). *For Medicare Part B, use M-8 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Form Locator 81 a-d — CC

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the 10-digit provider taxonomy code in the second field.