



Update
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Affected Programs: BadgerCare Plus, Medicaid

To: Advance Practice Nurse Prescribers with Psychiatric Specialty, Behavioral Treatment Providers, Case Management Providers, Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children Providers, Master's Level Psychotherapists, Nurse Practitioners, Occupational Therapists, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Physical Therapists, Physician Clinics, Physicians, Physician Assistants, Psychologists, Qualified Treatment Trainees, Speech-Language Pathologists, Substance Abuse Counselors, HMOs and Other Managed Care Programs

New ForwardHealth Behavioral Treatment Benefit

Effective for dates of service on and after January 1, 2016, ForwardHealth will begin coverage of the new behavioral treatment benefit. This *ForwardHealth Update* addresses the policy and program information for the new benefit.

Overview

Effective for dates of service (DOS) on and after January 1, 2016, ForwardHealth will begin coverage of the new behavioral treatment benefit. This new benefit was created in response to federal Centers for Medicare and Medicaid Services (CMS) guidance, issued in July 2014, requiring states to provide coverage of autism treatment through their statewide Medicaid programs. This *ForwardHealth Update* addresses the policy and program information for the new behavioral treatment benefit. The behavioral treatment benefit provides coverage of comprehensive and focused evidence-based treatments.

ForwardHealth requires that all licensed/certified medical professionals and qualifying paraprofessionals who provide behavioral treatment to ForwardHealth members be enrolled in Wisconsin Medicaid as behavioral treatment providers with one of the following provider specialties:

- Behavioral treatment licensed supervisor
- Behavioral treatment therapist
- Behavioral treatment technician

- Focused treatment licensed supervisor
- Focused treatment therapist

ForwardHealth first introduced the new benefit and outlined the enrollment criteria and enrollment process in the October 2015 *Update* (2015-55), titled "Provider Enrollment for the New Behavioral Treatment Benefit." Providers can access this *Update* from the ForwardHealth Publications page on the ForwardHealth Portal at www.forwardhealth.wi.gov/.

The behavioral treatment benefit will be administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. This benefit will be "carved out" for BadgerCare Plus and Medicaid SSI HMO members, with prior authorization (PA) requests and claims processed by ForwardHealth instead of the member's HMO.

This *Update* is for behavioral treatment benefit providers enrolled in Medicaid. Information from this *Update* will be included in the future Behavioral Treatment Benefit service area of the Online Handbook, detailed in the Online Handbook section of this *Update*. Providers should refer to this *Update* for policy and billing information that apply to the behavioral treatment benefit until the Behavioral Treatment Benefit service area of the Online Handbook becomes available in early 2016.

Covered Services

The ForwardHealth behavioral treatment benefit covers services designed specifically for adaptive behavior assessment and treatment. Treatment may be authorized for members with autism or other diagnoses or conditions associated with deficient adaptive or maladaptive behaviors.

Covered services within the following categories are covered under the behavioral treatment benefit:

- Behavior identification assessment and plan of care (POC) development
- Comprehensive behavioral treatment
- Focused behavioral treatment
- Behavioral treatment with protocol modification
- Family adaptive behavior treatment guidance
- Team meetings.

Refer to Attachment 1 of this *Update* for the allowable procedure codes and modifiers.

Note: The behavioral treatment benefit does not include screening or diagnostic services such as developmental screening, psychological testing, neuropsychological testing, genetic testing, or other necessary medical evaluations. ForwardHealth covers these services through existing benefits for physician services or outpatient mental health. A comprehensive diagnosis precedes a referral for behavioral treatment services. The Behavior Identification Assessment covered under the behavioral treatment benefit includes only those activities necessary to identify and define the behaviors to be addressed, establish the member's baseline performance, and develop a POC.

Behavior Identification Assessment and Plan of Care Development

ForwardHealth will cover clinical assessment activities used to identify target behaviors and to develop a POC (i.e., treatment plan, protocol) for the member. Covered assessment activities include:

- Face-to-face observation of the member
- Administration of standardized and non-standardized tests

- Detailed behavioral history
- Caregiver interview
- Interpretation of test result(s)
- Discussion of findings and recommendations with the primary caregiver(s)
- Preparation of a POC

These assessment activities must be conducted by licensed supervisors, although observational follow-up assessments may be designed by the licensed supervisor and implemented by a treatment therapist. One assessment is covered every six months per member for the provider submitting the treatment PA request. If more frequent assessment is needed, a PA request must be submitted. If the member changes providers, a different licensed supervisor may conduct his or her own assessment without submitting a PA request.

Follow-up assessments may be conducted only when they occur within 60 days of the previous behavioral identification assessment. A provider must submit a PA request to conduct a follow-up assessment more than 60 days after the initial behavior identification assessment.

Comprehensive Behavioral Treatment

The behavioral treatment benefit covers high-intensity, early-intervention comprehensive behavioral treatment typically lasting for a year or more. The aim of comprehensive treatment is for the member to acquire a broad base of skills (e.g., communication, social-emotional development, adaptive functioning) with an emphasis on “closing the developmental gap” between the member and same-age peers in the primary deficit areas associated with autism. The broad scope of goals and focus on early developmental impacts are the defining features of this treatment.

Comprehensive treatment must be administered face-to-face with the member. Only face-to-face services are reimbursable.

Hours of Treatment

ForwardHealth will authorize comprehensive treatment for no fewer than 20 hours per week at the outset of treatment.

Fewer than 20 hours of comprehensive treatment may be approved in the following situations:

- As part of a planned reduction in hours following a course of high-intensity treatment.
- For a narrower scope of goals, when the skill level of the treatment technicians is sufficient and appropriate for addressing the member's treatment needs.

ForwardHealth typically will not authorize comprehensive treatment hours that would place cognitive and social task demands on the member for more than 45 hours per week, including time spent in school and other therapies. However, treatment plans may exceed 45 hours per week in exceptional circumstances. For example, if the member is enrolled in school at the outset of comprehensive treatment, the 45-hour (inclusive) limit may be suspended for the initial PA, and possibly subsequent PA periods based on the member's progress. In addition, if the member was enrolled in a behavioral treatment program for greater than 45 hours per week prior to the PA request, including time spent in other interventions, the initial PA may be approved with guidance to reduce hours to the 45-hour (inclusive) limit. For these or any other appropriate situations, the provider is required to document the exceptional circumstances and/or research evidence of efficacy for requested hours that exceed ForwardHealth's guidelines.

Who May Provide Treatment

Comprehensive treatment may be provided by licensed supervisors, treatment therapists, or treatment technicians.

Location of Treatment

Treatment may occur in the member's home, the provider's office, or in the community.

Prior Authorization Required

All comprehensive treatment activities require an approved PA request. The comprehensive treatment approach must have adequate research evidence indicating its effectiveness for individuals comparable to the member (e.g., age, diagnostic status, behavioral and cognitive characteristics). For members with autism, current evidenced-based

comprehensive treatment modalities include Applied Behavior Analysis (ABA) and Early Start Denver Model (ESDM). Comprehensive treatment may continue to be authorized as long as the provider demonstrates the medical necessity of the proposed services for the member via the PA request process.

Focused Behavioral Treatment

ForwardHealth covers time-limited, lower-intensity treatment that focuses on specific behaviors or deficits. The aim of focused behavioral treatment is to reduce challenging behaviors of the member, develop replacement behaviors, and develop discrete skills that enhance personal independence. A narrow scope of goals is the defining feature of focused treatment, in contrast to the broad scope of goals with comprehensive treatment. Focused treatment must be administered face-to-face with the member. Only face-to-face services are reimbursable.

ForwardHealth will authorize focused treatment for members whose significant maladaptive behavior (e.g., aggression, self-injury, property destruction) or complex conditions (e.g., comorbid mental health diagnoses) require skilled direct treatment by licensed supervisors and/or treatment therapists. Treatment technicians are not considered adequately skilled to appropriately address the member's treatment needs in these situations.

Hours of Treatment

ForwardHealth typically will not authorize focused treatment hours that would place cognitive and social task demands on the member for more than 45 hours per week, including time spent in school and other therapies. However, treatment plans may exceed 45 hours per week in exceptional circumstances. For example, if the member is enrolled in school at the outset of comprehensive treatment, the 45-hour (inclusive) limit may be suspended for the initial PA, and possibly subsequent PA periods based on the member's progress. In addition, if the member was enrolled in a behavioral treatment program for greater than 45 hours per week prior to the PA request, including time spent in other interventions, the initial PA request may be approved with

guidance to reduce hours to the 45-hour (inclusive) limit. For these or any other appropriate situations, the provider is required to document the exceptional circumstances and/or research evidence of efficacy for requested hours that exceed ForwardHealth's guidelines.

Who May Provide Treatment

Focused treatment may be provided by licensed supervisors or treatment therapists.

Location of Treatment

Treatment may occur in the member's home, the provider's office, or in the community.

Prior Authorization Required

All focused treatment activities require an approved PA request. The focused treatment approach must have adequate research evidence indicating its effectiveness for individuals comparable to the member (e.g., age, diagnostic status, behavioral and cognitive characteristics) and must fall within the scope of practice of the requesting provider's training and credentials. Focused treatment will typically not be authorized for more than 12 continuous months per episode of treatment for the goals specified in the member's POC. Through the PA process, the provider must document the rationale for continued treatment beyond 12 months for a single treatment goal or set of treatment goals for a member. Focused treatment may be authorized for additional episodes of treatment for a different set of goals, as long as the provider demonstrates medical necessity for the proposed services via the PA approval process.

Behavioral Treatment with Protocol Modification

For both comprehensive and focused treatment, ForwardHealth covers services where the licensed supervisor or treatment therapist resolves issues with or otherwise makes changes to the existing treatment protocol or POC in order to improve outcomes for the member.

Adaptive behavior treatment with protocol modification is administered by the licensed supervisor or treatment

therapist who is face to face with a single member. The service may include demonstration of the new or modified protocol to a technician, guardian, and/or caregiver.

In general, providers may bill up to one hour of protocol modification for each five hours of direct behavioral treatment. Providers should document in the member's record situations in which protocol modification in excess of one hour for five hours of direct behavioral treatment is warranted.

Family Adaptive Behavior Treatment Guidance

As part of the overall behavioral treatment POC for the member, ForwardHealth covers treatment guidance provided to the member's family and caregivers by licensed supervisors or treatment therapists. The aim of family adaptive behavior treatment guidance is to teach parents and/or caregivers to properly use treatment procedures designed to teach new skills and reduce challenging behaviors. Covered activities include face-to-face instruction to parents and/or caregivers, without the member present, with a focus on identifying problem behaviors and deficits following the POC, to reduce maladaptive behaviors and/or skill deficits.

Family adaptive behavior treatment guidance requires an approved PA request and may be requested in addition to treatment hours with a member as part of a comprehensive or focused treatment PA request.

Team Meetings

ForwardHealth covers team meeting services in which licensed supervisors or treatment therapists meet with a member's parent(s) or caregiver(s) and treatment technician(s) to discuss the treatment POC and the member's progress. The member is not required to be present. Team meetings are reimbursed no more frequently than one time per week and must be prior authorized by ForwardHealth. Team meeting services are requested on the prior authorization request form (PA/RF) on a separate line item. See Attachment 4 for additional guidance. All

documentation requirements in Attachment 1 must be met for team meeting services to be reimbursable by ForwardHealth.

Noncovered Services

The following services are not covered by ForwardHealth under the behavioral treatment benefit:

- **Group therapy** — The behavioral treatment benefit does not cover therapy that involves a single provider serving multiple members concurrently during a single session (i.e., group therapy). If the member is participating in group activities with one-on-one support from a single provider, treatment is considered one-on-one and is covered.
- **Supportive services, such as respite care.**
- **Services that are primarily recreation-oriented.**
- **Noncovered services as defined in Wis. Admin. Code § DHS 107.02(2).**
- **Services that do not meet all clinical and coding guidelines enumerated in this *Update*.**

Services Not Separately Reimbursable

The following services are not separately reimbursable by ForwardHealth under the behavioral treatment benefit:

- **Travel** — Time spent travelling by the provider.
- **Case management services provided under Wis. Admin. Code § DHS 107.32.**

Coverage of Concurrent Services

ForwardHealth does not cover behavioral treatment concurrently with certain services. Other covered services that may not be delivered concurrently with behavioral treatment include:

- Adult mental health day treatment services
- Child/adolescent day treatment services
- Community recovery services
- Community support program services
- Comprehensive community services
- In-home mental health and substance abuse services for children
- Substance abuse day treatment services

This *Update* does not replace existing policy and requirements for the service areas listed above.

Co-treatment

Co-treatment is simultaneous treatment by two providers of different disciplines **during a single member encounter**.

Co-treatment may be authorized when the treatment approach is medically necessary to optimize the member's benefit from behavioral treatment. Behavioral treatment providers may provide co-treatment with the following types of providers:

- Therapy
- Outpatient mental health
- Private duty nursing

Behavioral treatment providers are required to specify on the initial PA request or on a PA amendment request the plan for co-treatment with another provider. Co-treatment occurs when the member is present with both providers for a joint intervention, but it does not include professional collaboration or consultation. Co-treatment requests should address the specific and unique contribution of each provider.

If co-treatment is approved, two providers of different disciplines can be reimbursed by ForwardHealth for the same time period. For example, if a member is treated by a speech and language pathology (SLP) provider and a behavioral treatment provider from 1:00 p.m. to 2:00 p.m., both providers could receive ForwardHealth reimbursement for one hour of treatment time. However, if co-treatment is not approved, both the SLP provider and the behavioral treatment provider would not receive reimbursement for one hour. Instead, each provider could receive reimbursement for 30 minutes of treatment time.

Care Collaboration

Care collaboration (or case sharing) is treatment by two providers of different disciplines **during overlapping episodes of care** but does not include co-treatment.

Behavioral treatment providers may share a case with the following types of providers:

- Personal care
- Therapy
- Outpatient mental health
- Case management
- Home health services

Behavioral treatment providers are required to document their communication with these other providers regarding the member's needs, POC, and scheduling. This will ensure coordination of services and continuity of care and will prevent duplication of services provided to a member.

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription, and documentation requirements.

Policy Information

In order to ensure adherence to program requirements, providers should verify that they have the most current sources of policy information. It is critical that providers and staff have access to these documents:

- **Wisconsin Administrative Code** — Wis. Admin. Code chs. DHS 101–108 are the rules regarding Medicaid administration.
- **Wisconsin Statutes** — Wis. Stat. §§ 49 provides the legal framework for Wisconsin Medicaid.
- **ForwardHealth Online Handbook** — The Online Handbook contains policy information for all providers.

Documentation Requirements

Behavioral treatment providers are required to maintain documentation in accordance with Wis. Admin. Code ch. DHS 106 and other applicable laws and rules. According to Wis. Admin. Code § DHS 106.02(9)(f), covered services are not reimbursable under Wisconsin Medicaid unless the documentation and medical record keeping requirements are

met. Providers are required to be able to produce documentation upon request from the Department of Health Services (DHS) or federal auditors. Documentation is evaluated by the DHS during the audit process.

Prior Authorization

All behavioral treatment services require an approved PA request in order to receive reimbursement from ForwardHealth. Prior authorization is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. ForwardHealth has established clinical criteria for PA requests for behavioral treatment effective for DOS on and after January 1, 2016. Refer to Attachment 2 for behavioral treatment PA approval criteria.

Medical Necessity

In order for a PA request for behavioral treatment to be approved, the provider is required to submit sufficiently detailed information to meet ForwardHealth's definition of "medically necessary," as outlined in Wis. Admin. Code § DHS 101.03(96m). Prior authorization requests are approved for a specific period of time and indicate the type and quantity of service allowed for a specific member. Wis. Admin. Code ch. DHS 107 outlines the purposes and requirements related to PA.

Providers are required to submit complete and accurate information about the member's current condition and needs in order to substantiate the requested services.

ForwardHealth's consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. ForwardHealth will return PA requests that do not supply sufficiently detailed information.

Forms and Attachments

All of the following must be included as part of the PA request for behavioral treatment:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/13).
- A completed Prior Authorization/Behavioral Treatment Attachment (PA/BTA), F-01629 (12/2015).

- Documentation supporting the criteria outlined in Attachment 2.

Prior Authorization Request Form

The PA/RF is used by ForwardHealth and is mandatory for most providers when requesting PA. The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique 10-digit number. ForwardHealth remittance information will report to the provider the PA number used to process the claim for prior authorized services.

The PA/RF is located on the Forms page of the Portal. The PA/RF completion instructions for behavioral treatment are included as Attachment 3.

Prior Authorization Request Form Sample

ForwardHealth has created a sample PA/RF and is included as Attachment 4.

The information presented in the sample is for illustrative purposes only and does not constitute guidance from ForwardHealth regarding specific entries that a provider should make on a PA/RF for a specific PA request for a specific member.

Prior Authorization/Behavioral Treatment Attachment

The PA/BTA must be submitted with each PA request. The PA/BTA allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

The PA/BTA completion instructions are located on the Forms page of the Portal and as Attachment 5. The

PA/BTA form is also located on the Forms page of the Portal and as Attachment 6.

Submission Options

Behavioral treatment providers may submit PA requests for behavioral treatment services using any of the following methods:

- **ForwardHealth Portal** — Prior authorization requests may be submitted on the ForwardHealth Portal at www.forwardhealth.wi.gov/.
- **Fax** — Prior authorization requests may be faxed to 608-221-8616.
- **Mail** — Prior authorization requests may be mailed to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

For specific information about each of these submission options, providers should refer to the Submission Options chapter of the Prior Authorization section of the Physician service area of the Online Handbook.

Verifying Member Enrollment

Providers should always verify a member's enrollment prior to submitting a PA request **and** before rendering services; this allows the provider to review the member's coverage, since a member's enrollment status may change without notice. Providers can access Wisconsin's Enrollment Verification System (EVS) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, the ForwardHealth automated voice response system, which provides responses to inquiries about claim status (800-947-3544)
- Commercial enrollment verification vendors
- The 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions
- Provider Services at 800-947-9627

Each enrollment verification method allows providers to verify the following:

- A member's enrollment in a ForwardHealth program(s)
- State-contracted managed care organization (MCO) enrollment
- Medicare enrollment
- Any other commercial health insurance coverage
- Exemption from copayments for BadgerCare Plus members

Note: The EVS does not indicate other government programs that are secondary to ForwardHealth. Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

Authorization Dates

The requested start date for services on PA requests cannot precede the date of the medical examination, diagnostic evaluation, or prescription from a physician or medical provider authorized to write a prescription (e.g., a nurse practitioner or physician assistant).

Note: *Current Procedural Terminology* (CPT) guidance refers to these providers as “other qualified health care professionals.”

Prior authorization requests may not be backdated to a date that is earlier than the initial date of the PA request submission. Services provided prior to the PA start date or after the PA end date are not considered authorized and will not be covered.

Initial PA requests for behavioral treatment services should be submitted for no more than six months of treatment. Subsequent PA requests for the same member may be submitted for up to 12 months of treatment. The authorization period granted may be shorter or longer than the request, depending on individual circumstances related to the demonstration of medical necessity.

Prior Authorization Status Inquiries and Decisions

Providers may inquire about the status of a PA request through one of the following methods, using the 10-digit PA number received following submission of a PA request:

- Accessing WiCall at 800-947-3544
- Calling Provider Services at 800-947-9627

Refer to the Prior Authorization section of the Physician service area of the Online Handbook for more information on PA status and decisions.

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following applies:

- The service authorized on the approved PA request is not the service provided.
- The service is not provided within the grant and expiration dates on the approved PA request.
- The member is not eligible for the service on the date the service is provided.
- The provider is not enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is not billed according to service-specific claim instructions.
- The provider does not meet other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider failed to submit a PA request before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained an approved PA request but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA request was denied.

Communication with Members

ForwardHealth recommends that providers inform members that an approved PA request is required for certain specified services before delivery of the services. Providers should also explain that they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the PA process.

Member Questions

A member may call Member Services at 800-362-3002 to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Prior Authorization Coding Guidance

All direct treatment hours (represented by CPT codes 0364T through 0369T) must be requested as a single lump sum using CPT code 0365T (Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time [List separately in addition to code for primary procedure]). Family adaptive behavior treatment guidance hours must be requested separately using CPT code 0370T (Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional [without the patient present].)

Prior Authorization Amendments

Providers are required to use the Prior Authorization Amendment Request, F-11042 (07/12), to amend an approved or modified PA request. Examples of when providers may request an amendment include the following:

- To add or change a procedure code
- To change the grant or expiration date
- To temporarily modify a member's frequency of service when there is a short-term change in his or her behavioral treatment POC
- To enddate a PA when a member chooses to discontinue receiving prior authorized services

- To enddate a PA when a licensed supervisor chooses to discontinue delivering prior authorized services
- To enddate a PA when the service is no longer medically necessary
- To identify co-treatment
- To amend a PA end date beyond the original expiration date. An approved or modified PA request initially approved for less than 12 months may be amended for up to a total of 12 months if additional services are medically necessary

The request to amend the PA must include the following:

- The Prior Authorization Amendment Request form
- The specific, requested changes (be as specific as possible)
- Documentation justifying the requested change. This may include the POC, a new written report of the member's evaluation, progress summary, etc.
- A corresponding prescription from a physician or medical professional, if needed
- If the amendment request is to amend a PA end date beyond the original expiration date, an updated POC, progress summary, and updated behavioral treatment team (if there are changes in the team composition). The provider is required to include all documentation that was requested by ForwardHealth in the previous PA grant letter.

Note: Under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in the services required.

ForwardHealth may approve a PA amendment request if the request is:

- Fully explained and documented. Clinical documentation of the medical necessity justifying the request is required.
- Medically necessary under Wis. Admin. Code § DHS 101.03(96m)
- Submitted before the date of the requested change
- Submitted before the PA expires

- Not solely for the convenience of the member, the member's family, or the provider
- Not requested to allow for a vacation, missed appointments or treatment sessions, illness, or a leave of absence by the provider

Claims and Claims Adjustments

Behavioral treatment licensed supervisors and focused treatment licensed supervisors submit claims to ForwardHealth for behavioral treatment services. Information on claims submission to ForwardHealth is found in the ForwardHealth Online Handbook. Behavioral treatment providers should refer to the following topics in the Submission chapter of the Claims section of the Physician service area of the Online Handbook for claims submission guidance:

- The 1500 Health Insurance Claim Form Completion Instructions topic (topic #17797)
- The Copy Claims on the ForwardHealth Portal topic (topic #6957)
- The Correct Errors on Claims and Resubmit to ForwardHealth on the Portal topic (topic #5017)
- The Direct Data Entry of Professional and Institutional Claims on the Portal topic (topic #4997)
- The Electronic Claim Submission topic (topic #344)
- The HIPAA-Compliant Data Requirements topic (topic #4837)
- The Note Field for Most Claims Submitted Electronically topic (topic #10837)
- The Paper Claim Form Preparation and Data Alignment Requirements topic (topic # 561)
- The Paper Claim Submission topic (topic # 642)
- The Prior Authorization Numbers on Claims topic (topic # 10177)
- The Reimbursement Reduction for Most Paper Claims topic (topic # 10637)
- The Submitting Paper Attachments with Electronic Claims topic (topic # 4817)
- The Uploading Claim Attachments Via the Portal topic (topic # 11677)

Guidance on conducting a topic search in the Online Handbook is found in Attachment 7.

Claims submission guidance specific to the ForwardHealth behavioral treatment benefit is included below. Refer to Attachment 8 for 1500 Health Insurance Claim Form completion instructions for behavioral treatment services.

Procedure Codes and Modifiers

Use of CPT procedure codes and applicable modifiers is required on all claims. Claims or claim adjustments received without a CPT code and corresponding modifier will be denied. Refer to Attachment 1 for the allowable procedure codes and modifiers for behavioral treatment services.

Providers are required to include a modifier with the procedure code to indicate the type of treatment (comprehensive or focused) that was provided. ForwardHealth recognizes modifier TG for comprehensive treatment claims and TF for focused treatment claims. In addition to the TG or TF modifiers, providers are also required to submit modifier AM when submitting claims for team meetings. Each line of detail submitted on a claim or claim adjustment requires a modifier. Claims and claim adjustments submitted without the required modifier will be denied.

ForwardHealth is required to comply with the CMS National Correct Coding Initiative (NCCI) standards. If NCCI standards change, ForwardHealth will comply with the updated standards.

Place of Service

Behavioral assessment and treatment may occur in either the home, clinic, or community. Allowable place of service (POS) codes for the behavioral treatment benefit are listed in Attachment 9.

The following POS are **not** allowed under the behavioral treatment benefit:

- Residential Care Centers

- Intermediate care facilities, skilled nursing facilities or institutions for mental disease, or hospitals

Claims for Services Prescribed, Referred, or Ordered

Claims for services that are prescribed, referred, or ordered must include the National Provider Identifier of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. ForwardHealth considers behavioral treatment services to require a prescribing, referring, or ordering provider. Refer to the Prescribing/Referring/Ordering Providers information on the Provider Enrollment Information page of the Portal for additional information on prescribing/referring/ordering providers.

Coordination of Benefits

Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is accomplished by following the process in the Exhausting Commercial Health Insurance Sources topic (topic #596) of the Commercial Health Insurance chapter of the Coordination of Benefits section of the Online Handbook. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Except for emergency services and covered services that are not covered under the commercial health insurance plan, members enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid (i.e., state-contracted MCO, fee-for-service) are required to receive services from providers affiliated with the commercial health insurance plan. In this situation, providers are required to refer the member to the commercial health insurance plan's network providers.

BadgerCare Plus and Wisconsin Medicaid will not reimburse the provider if the commercial health insurance plan denied,

or would deny payment, because a service otherwise covered under the commercial health insurance plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside his or her commercial health insurance plan network of providers, the provider cannot collect payment from the member.

If commercial health insurance denies or only partially reimburses for a claim, the provider may submit a claim to ForwardHealth. This can include claims for services not reimbursed by commercial insurance and for the member's deductibles, copayments, and coinsurance. An approved PA must be in place with ForwardHealth in order to seek reimbursement from ForwardHealth.

Procedure Codes for Claims When Private Health Insurance Is the Primary Payer

In order to coordinate benefits and reimbursement for members who also have private insurance, ForwardHealth will allow the following CPT codes, which may be used by commercial health insurance companies for behavioral treatment services, in addition to ForwardHealth-allowed codes (refer to Attachment 1):

- 90791 (Psychiatric diagnostic evaluation)
- 97532 (Development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes)
- H0031 (Mental health assessment, by non-physician)
- H0032 (Mental health service plan development by non-physician)
- H2012 (Behavioral health day treatment, per hour)
- H2019 (Therapeutic behavioral services, per 15 minutes)

Providers are required to bill private health insurance first, using the CPT code set specified by the member's commercial health insurer. After commercial health insurance has paid its portion, the provider may submit a claim to ForwardHealth along with the explanation of benefits, using the same CPT codes used on the private health insurance claim. All units of direct treatment billed against the previously listed CPT codes will be deducted

from the total treatment units authorized by ForwardHealth under CPT procedure code 0365T.

Reimbursement

Providers are reimbursed at the lesser of their billed amount or the maximum allowable fee for the service.

ForwardHealth establishes maximum allowable fees for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

ForwardHealth maximum allowable fees for behavioral treatment services are available in Attachment 10.

Member Information

Eligible Members

The behavioral treatment benefit is available to all BadgerCare Plus or Medicaid members who demonstrate medical necessity for covered services. Members are not required to be evaluated using the Wisconsin Functional Screen to determine if ForwardHealth-covered behavioral treatment services are appropriate for the member.

Copayment

Providers are prohibited from collecting copayments from members for services covered under the behavioral treatment benefit.

Fee-for-Service Benefit

The behavioral treatment benefit is a fee-for-service benefit for all BadgerCare Plus or Medicaid members, including members enrolled in a Medicaid HMO or MCO.

Retroactive Medicaid Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the

enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period.

Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-enrolled provider for a covered service during the period of retroactive enrollment, according to Wis. Admin. Code § DHS 104.01(11). A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

If a provider receives reimbursement from Medicaid for a service provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (if the services provided during the period of retroactive enrollment were covered).

Resources

Various resources are available to help providers be successful in doing business with ForwardHealth.

Information regarding provider resources is located in the Online Handbook.

ForwardHealth Updates

Updates are the first source of provider information and announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also includes an Updates and Handbooks link to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*. A Behavioral Treatment Benefit page is available under the Service/Program Specific *Updates* box on the ForwardHealth Publications page, which directly links to published *Updates* applicable to behavioral treatment providers.

Note: Information from this *Update* will be incorporated into a new Behavioral Treatment service area of the Online Handbook in early 2016. Providers should use this *Update* for all policy and billing information until the Behavioral Treatment service area becomes available.

Online Handbook

The Online Handbook, accessible from a link in the Providers box on the Portal home page, allows providers access to all policy and billing information for Wisconsin Medicaid and BadgerCare Plus in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections and chapters. Sections within each handbook may include the following:

- Claims
- Coordination of Benefits
- Managed Care

- Member Information
- Prior Authorization
- Provider Enrollment and Ongoing Responsibilities
- Reimbursement
- Resources

Each section consists of separate chapters (e.g., claims submission, procedure codes), which contain further detailed information.

Behavioral Treatment Service Area of the Online Handbook

Policies included in this *Update* are specific to the behavioral treatment benefit. Information about this benefit will be added to the Online Handbook on the Portal in early 2016. Providers should review the Behavioral Treatment Benefit service area of the Online Handbook, when available, for complete and more detailed information about the benefit.

Until the Behavioral Treatment Benefit service area of the Online Handbook becomes available, providers should refer to the Physician service area of the Online Handbook for policy that affects all provider types and to this *Update* for all policy information specific to the behavioral treatment benefit.

Electronic messaging to Portal accounts and Behavioral Treatment Benefit email subscribers, detailed in the Electronic Notifications from ForwardHealth section of this *Update*, will be sent when the Behavioral Treatment Benefit service area of the Online Handbook is available. Providers should review the Behavioral Treatment Benefit service area of the Online Handbook, when available, for complete and more detailed information about the benefit.

Electronic Notifications from ForwardHealth

ForwardHealth sends Portal account messaging and email subscription messaging to notify providers of newly released *Updates* and the monthly *ForwardHealth Update Summary*. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely

information. Providers who have established a ForwardHealth Portal account automatically receive notifications from ForwardHealth in their Portal Messages inbox. Providers and other interested parties may register to receive email subscription notifications.

Email Subscription

ForwardHealth has established the Behavioral Treatment Benefit email subscription option and will use this email subscription to communicate new information regarding the benefit. Refer to the ForwardHealth Portal E-mail Subscription User Guide accessible via the Portal User Guides link on the Provider home page of the Portal for instructions on how to sign up for email subscriptions. Any number of staff or other interested parties from an organization may sign up for an email subscription and may select multiple subscription options.

User Guides and Instruction Sheets

Portal user guides and instruction sheets provide step-by-step instructions on how to work through various functional areas of the Portal such as:

- Member Enrollment Verification
- Prior Authorization
- Claims Functionality

A link to the user guides is located on the Providers page of the Portal.

Provider Services

Providers should call Provider Services at 800-947-9627 for answers to enrollment, policy, and billing questions.

Provider Services is organized to include program-specific and service-specific assistance to providers. Provider Services supplements the Portal and WiCall by providing information on the following:

- Billing and claim submissions
- Provider enrollment
- Coordination of Benefits (e.g., verifying a member's other health insurance coverage)
- Assistance with completing forms

- Assistance with remittance information and claim denials
- Policy clarification
- Prior authorization status
- Verifying covered services

Member Services

Members should call Member Services at 800-362-3002 for information. Members should **not** be referred to Provider Services.

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 AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

P-1250

This *Update* was issued on 12/28/2015 and information contained in this *Update* was incorporated into the Online Handbook on 02/22/2016.

ATTACHMENT 1

Procedure Code Information for the Behavioral Treatment Benefit

The following table lists the procedure code and modifiers that providers are required to use when submitting claims under the behavioral treatment benefit.

Procedure Code	Procedure Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (<i>Note: Subject to Industry Change</i>)	Required Documentation	PA Limits
0359T	Behavior identification assessment , by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.	TG (comprehensive) or TF (focused)	Licensed supervisor	MUE=1 <ul style="list-style-type: none"> This code is considered a single unit of service regardless of the number of hours or days required to complete the assessment. The date of service (DOS) is reported as the date the assessment is completed. 	<ul style="list-style-type: none"> Time in/time out Names of staff and caregiver(s) present Place of service Assessment report Plan of care Renderer signature 	Prior authorization required for assessment of member more than one time per six months per provider.

Procedure Code	Procedure Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (<i>Note: Subject to Industry Change</i>)	Required Documentation	PA Limits
0360T	Observational behavioral follow-up assessment , includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	TG (comprehensive) or TF (focused)	Licensed supervisor or treatment therapist	MUE=1 <ul style="list-style-type: none"> Do not report less than 16 minutes of face-to-face technician time (subject to <i>Current Procedural Terminology</i> [CPT] Time-Rule for face-to-face technician time). Includes time spent by physician or other qualified health care professional involved in technician tasks is considered technician time. Only the time of one technician is reported when more than one is in attendance. 	<ul style="list-style-type: none"> Time in/time out Names of staff and caregiver(s) present Place of service Assessments completed Renderer signature 	Prior authorization required for assessment of member more than two months after 0359T service date.

Procedure Code	Procedure Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (<i>Note: Subject to Industry Change</i>)	Required Documentation	PA Limits
0361T	Observational behavioral follow-up assessment , includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	TG (comprehensive) or TF (focused)	Licensed supervisor or treatment therapist	MUE=3 <ul style="list-style-type: none"> Add-on code that must be used in conjunction with 0360T. Do not report less than 16 minutes of face-to-face technician time (subject to CPT Time-Rule for face-to-face technician time). 	<ul style="list-style-type: none"> Time in/time out Names of staff and caregiver(s) present Place of service Assessments completed Renderer signature 	Prior authorization required for assessment of member more than two months after 0359T service date.
0364T*	Adaptive behavior treatment by protocol , administered by technician, face-to-face with one patient; first 30 minutes of technician time.	TG (comprehensive) or TF (focused)	Any level of behavioral treatment provider for comprehensive. Licensed supervisor and treatment therapist for focused.	MUE=1	<ul style="list-style-type: none"> Time in/time out Names of staff and caregiver(s) present Place of service Goals addressed Data collected regarding goals Renderer signature 	Prior authorization required

Procedure Code	Procedure Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (<i>Note: Subject to Industry Change</i>)	Required Documentation	PA Limits
0365T*	Adaptive behavior treatment by protocol , administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	TG (comprehensive) or TF (focused)	Any level of behavioral treatment provider for comprehensive. Licensed supervisor and treatment therapist for focused.	Add-on code that must be used in conjunction with 0364T.	<ul style="list-style-type: none"> • Time in/time out • Names of staff and caregiver(s) present • Place of service • Goals addressed • Data collected regarding goals • Renderer signature 	Prior authorization required
0366T*	Group adaptive behavior treatment by protocol , administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	TG (comprehensive) or TF (focused)	Any level of behavioral treatment provider for comprehensive. Licensed supervisor and treatment therapist for focused.	MUE=1	<ul style="list-style-type: none"> • Time in/time out • Names of staff and caregiver(s) present • Place of service • Goals addressed • Data collected regarding goals • Renderer signature 	Prior authorization required

Procedure Code	Procedure Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (<i>Note: Subject to Industry Change</i>)	Required Documentation	PA Limits
0367T*	Group adaptive behavior treatment by protocol , administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	TG (comprehensive) or TF (focused)	Any level of behavioral treatment provider for comprehensive. Licensed supervisor and treatment therapist for focused.	Add-on code that must be used in conjunction with 0366T .	<ul style="list-style-type: none"> • Time in/time out • Names of staff and caregiver(s) present • Place of service • Goals addressed • Data collected regarding goals • Renderer signature 	Prior authorization required
0368T*	Adaptive behavior treatment with protocol modification , administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time.	TG or TF	Licensed supervisor or treatment therapist	MUE=1	<ul style="list-style-type: none"> • Time in/time out • Names of staff and caregiver(s) present • Narrative description of observations, changes implemented or feedback provided, and outcome of changes/feedback • Renderer signature 	Prior authorization required

Procedure Code	Procedure Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (Note: Subject to Industry Change)	Required Documentation	PA Limits
0369T*	Adaptive behavior treatment with protocol modification , administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	TG or TF	Licensed supervisor or treatment therapist	Add-on code that must be used in conjunction with 0368T.	<ul style="list-style-type: none"> Time in/time out Names of staff and caregiver(s) present Narrative description of observations, changes implemented or feedback provided, and outcome of changes/feedback Renderer signature 	Prior authorization required
0370T*	Family adaptive behavior treatment guidance , administered by physician or other qualified health care professional (without the patient present)	TG (comprehensive) or TF (focused) For team meetings: AM, in addition to modifier TG or TF.	Licensed supervisor or treatment therapist	MUE=1 <ul style="list-style-type: none"> This is not a time-based service. The service is face to face with parent or caregiver. Member is not present. 	<ul style="list-style-type: none"> Time in/time out Names of staff and caregiver(s) present Information collected from family Information shared with family Updates to plan of care (POC) or family goals, if any Renderer signature 	Prior authorization required

* To simplify the PA submission process, providers may request all direct treatment units for CPT codes 0364T, 0365T, 0366T, 0367T, 0368T, and 0369T by including the cumulative total of requested treatment units as a single line item, using a single code (0365T). Claims submitted using any of these CPT codes will be decremented against the cumulative total of approved treatment units.

ATTACHMENT 2

Prior Authorization Guidelines for the Behavioral Treatment Benefit

Prior Authorization Approval Criteria

Prior authorization (PA) requests for behavioral treatment services are reviewed to evaluate whether or not each service being requested meets ForwardHealth's definition of "medically necessary," as well as other criteria. The Prior Authorization/Behavioral Treatment Attachment (PA/BTA), F-01629 (12/2015), allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service.

ForwardHealth considers certain factors when determining whether to approve or deny a PA request pursuant to Wis. Admin. Code § DHS 107.02(3). Providers are required to include adequate information on the PA/BTA for ForwardHealth consultant(s) performing the clinical review to determine whether the service(s) being requested meets all of the elements of ForwardHealth's definition of "medically necessary." Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to Wis. Admin. Code § DHS 101.03(96m), a service that meets certain criteria is medically necessary under Wis. Admin. Code ch. DHS 107. Each PA is evaluated on its own merits. Providers are also required to prepare, submit, and maintain written documents that are complete, accurate, legible, and based on the current needs of the member (Wis. Admin. Code ch. DHS 106).

Approval criteria required to make a determination of medical necessity for behavioral treatment is included for the following scenarios:

- Initial PA requests
- Prior authorization amendments
- Subsequent PA requests

Approval Criteria for Initial PA Requests

An initial PA request is the first request to ForwardHealth for coverage of services for a member for an episode of behavioral treatment, even if the member's behavioral treatment is already in progress but covered by a payer other than Wisconsin Medicaid. The following information is required to make a determination of medical necessity for an initial PA request:

- Diagnostic evaluation
- Provider's initial assessment
- Previous treatment history
- Medical evaluation
- Standardized testing
- Behavioral treatment team
- Plan of care (POC)
- Care collaboration plan
- Supporting documents

Diagnostic Evaluation

Diagnostic evaluation, which includes both psychological and neuropsychological testing, is covered under the ForwardHealth mental health benefit when performed by a Medicaid-enrolled licensed physician or psychologist. A diagnostic report is required to be submitted with the PA request.

For comprehensive behavioral treatment, the diagnostic report must be dated within one year of the PA request, or for individuals continuously enrolled in a behavioral treatment program prior to the PA request, within one year of the onset of the member's current course of treatment.

For focused behavioral treatment, diagnostic reports dated more than one year prior to the PA request are acceptable. However, the provider is required to include an updated clinical impression of the member's diagnostic status in the initial assessment.

ForwardHealth requires documentation of the following elements in the diagnostic report:

- Detailed interview regarding developmental, medical, family, educational, and intervention history.
- Use of a diagnostic tool that is validated in peer-reviewed clinical literature and appropriate for the condition being evaluated, and which is administered according to protocol (e.g., for autism spectrum disorders [ASD], the Autism Diagnostic Observation Schedule-2 [ADOS-2], Autism Diagnostic Interview-Revised [ADI-R], and Childhood Autism Rating Scale [CARS-2] are examples of validated tools appropriate for diagnosing autism).
- Direct observation of the member, including written descriptions of clinical observations.
- Direct probing of the member to assess specific skills, including descriptions of findings.
- Review of relevant records (e.g., medical, Birth to 3, school, outside therapies).
- Consultation with other professionals, for members with comorbid medical or mental health conditions that may contribute to the presenting symptoms.
- Discussion of additional symptoms, possible or actual co-morbid conditions, and differential diagnosis.

If documentation in the member's medical record indicates potential or actual co-morbid conditions that could impact behavioral treatment, and that are not adequately clarified in the diagnostic report, ForwardHealth may request an independent diagnostic evaluation.

Provider's Initial Assessment

The provider requesting behavioral treatment services is required to submit his or her written initial assessment of the member, completed prior to the current course of behavioral treatment. If the initial assessment is more than three months old, or if the member has participated in behavioral treatment since the initial assessment, the requesting provider should include a brief addendum describing the member's current strengths, functional skills, limitations, and behavioral concerns, as well as updates on any background details that have changed. The initial assessment must include:

- The member's developmental and medical history.
- The member's current living arrangements and family supports.
- The member's current school or vocation.
- The member's current array of treatments and supportive services.
- Past mental health or behavioral health treatment and outcomes.
- The member's strengths and functional skills, including provider's observations.
- The member's limitations and behavioral concerns, including the provider's observations.

- Appropriateness of the provider's treatment approach for meeting the member's demonstrated needs.
- Discussion of any factors that may impact the member's response to treatment.

The requesting provider's current clinical impression of the member's diagnostic status must be included when the member's diagnostic report is dated more than one year prior to the PA request. When the member's records indicate differences of opinion among professionals who have evaluated or treated the member for conditions related to the diagnosis, the requesting provider is required to address and reconcile these differences in the initial assessment.

Previous Treatment

Prior authorization requests must include information about all treatments previously received by the member and related to the member's current deficits. This includes, but is not limited to: behavioral treatment, speech therapy, occupational therapy, physical therapy, daily living skills training, and psychotherapy.

Based on information collected from the member, member's caregivers, or the member's records, the requesting provider is required to indicate the effectiveness of previous interventions and the reason for discontinuing the interventions (e.g., aged out, goals mastered). If response to intervention was complex, the requesting provider should summarize the member's outcomes in the initial assessment.

Medical Evaluation

The member must have completed a comprehensive medical examination no more than 12 months prior to the submission of the PA request. Medical examinations for members younger than age 21 must comply with HealthCheck screening guidelines. Refer to the HealthCheck (EPSDT) service area of the ForwardHealth Online Handbook for additional information.

The requesting provider is required to obtain information from the member's medical provider regarding specific facets of the member's health that might impact the member's participation and/or expected outcomes from behavioral treatment. This includes:

- Hearing and vision screenings. Formal testing is not required if the screening indicates functioning within normal limits.
- Genetic testing. Tests are required if concerns are noted by the medical provider.
- Medical concerns. These include seizure disorders, attention problems, sleep concerns, digestive problems, elimination problems, nutrition concerns, depression concerns, or other issues noted by the medical provider. Relevant follow-up findings should be included.
- Current medications.

The provider is required to maintain on file written, signed, and dated documentation from the member's current medical provider with regard to each item detailed above.

Standardized Testing

Standardized testing or other formal assessments are required to establish the member's baseline prior to the provision of treatment, and may be required to evaluate progress periodically. Different types of testing are required for comprehensive and focused treatment.

Comprehensive treatment: The member's developmental age norms should be assessed across a range of skill areas to include cognitive functioning (e.g., IQ, developmental age equivalents), communication skills (e.g., receptive and expressive language measures), and life skills (e.g., socialization, motor functioning, adaptive skills). Standardized age-normed testing to establish the member's baseline is required prior to treatment. Recent assessment reports completed by qualified professionals from other agencies or school districts may be submitted. Behavioral Identification Assessment (0359T) and Observational Behavioral Follow-up Assessment (0360T/0361T) are covered services that may be used by the requesting provider to complete baseline testing prior to submitting a PA request for treatment and for periodic re-assessments during the member's course of treatment.

Focused treatment: The member's specific skill limitations (e.g., tolerating change, social communication skills, self-care skills) should be assessed using standardized measures, or as appropriate, a functional behavior assessment (FBA) should be completed to identify the function of the problem behavior and develop an effective treatment protocol. Recent standardized assessment reports completed by qualified professionals from other agencies or school districts may be submitted. Functional behavior assessments must be current and conducted by the requesting provider. When previous efforts at behavior change have been unsuccessful for very challenging behavior (e.g., aggression, self-injury, destructive behavior), a functional analysis of behavior may be required. Behavioral Identification Assessment (0359T) and Observational Behavioral Follow-up Assessment (0360T/0361T) are covered services that may be used by the requesting provider to complete this testing or assessment prior to submitting a PA request for treatment and for periodic re-assessment for treatment planning.

If the only service requested is Family Adaptive Behavior Treatment Guidance (0370T), standardized testing may be omitted from the PA request.

Behavioral Treatment Team

The provider is required to establish that the treatment team's skills and experience are adequate and appropriate for the member's assessed needs, and that unlicensed staff will receive adequate professional supervision to ensure quality treatment. For focused treatment, which utilizes direct service providers with advanced knowledge, skills, and clinical judgment, the provider is required to establish that more experienced clinicians are required to meet the member's needs. Providers are required to indicate the amount of direct treatment delivered to the member by each provider specialty during a typical week. ForwardHealth recognizes that exceptional circumstances may occasionally result in changes to the typical treatment schedule.

If the member is a dual-language learner, the PA request must describe the team's training and accommodations to address language barriers, including the primary language that will be used during therapy activities. In addition, the provider is required to document the plan for the family to practice language learning activities outside of sessions, if the primary language used during treatment is not the parents' first spoken language. If specialized training or skills are required for team members who will be serving dual language learners, this should be documented.

To ensure quality programming, the licensed supervisor is required to see the member often enough to confirm data and narrative progress reports provided by the team and is required to directly observe the member for at least one hour every 60 to 75 days. These visits must be documented by a detailed progress note or report and by claims submitted by the licensed supervisor for behavior assessment, behavior treatment, protocol modification, or family adaptive behavior treatment guidance. If more than 75 days elapse between supervisory visits, ForwardHealth may recoup all payments made for services delivered after day 75 until the next supervisory visit occurs.

Professional supervision: To ensure program quality, treatment therapists (comprehensive and focused) must be supervised regularly by licensed supervisors through a combination of direct and indirect supervision activities. Direct case supervision includes face-to-face observation of the treatment therapist implementing the POC with the member and/or family present. Indirect supervision may include activities such as oversight of treatment protocol, updating goals, data and progress review, crisis intervention, and family/team management and may occur face-to-face or via telephone or electronic communication, through individual or group contact. Documentation of weekly professional supervision (direct or indirect) and monthly direct case supervision is required for each treatment therapist. Documentation of monthly direct case supervision is required for each treatment technician. The frequency, mode, and provider of supervisory activity must be detailed in the PA request. Refer to the Prior Authorization section of this *Update* for additional requirements.

Comprehensive treatment: Direct services are typically provided by behavioral treatment technicians but may be provided by behavioral treatment licensed supervisors or behavioral treatment therapists. Behavioral treatment technicians must receive direct, face-to-face case supervision during delivery of direct treatment, with the member present, from either a treatment therapist or licensed supervisor. ForwardHealth requires a minimum of one hour of direct case supervision per 10 hours of direct treatment provided by treatment technicians. If direct case supervision exceeds two hours per 10 hours of direct treatment by treatment technicians, the provider is required to document the exceptional circumstances, such as a significant change in the member's response to treatment that resulted in a temporary need to increase direct supervision.

Focused treatment: Direct services may be provided by focused treatment licensed supervisors or focused treatment therapists. Focused treatment therapists must receive direct, face-to-face case supervision during delivery of direct treatment, with the member present, from the licensed supervisor. ForwardHealth requires a minimum of one hour of direct case supervision per 10 hours of direct treatment provided by the treatment therapist. If direct case supervision exceeds two hours per 10 hours of direct treatment by treatment therapists, the provider is required to document the exceptional circumstances, such as a significant change in the member's response to treatment that resulted in a temporary need to increase direct supervision.

Plan of Care

The POC must indicate the intended start and end dates for the authorization period, the intended treatment hours per week, and when required, a plan to modify treatment intensity over the course of the authorization period. All dates in the authorization period must fall within the date range specified on the prescription from a physician or medical provider for treatment.

The POC must also indicate the treatment approach that will be used. ForwardHealth limits coverage to treatment modalities that are evidence-based as determined by the Department of Health Services. The POC must be signed and dated by the supervising provider prior to provision of care.

For members seeking comprehensive treatment for ASDs, providers are expected to use a curriculum of treatment goals developed for individuals with ASD, addressing skills across a range of developmental areas (e.g., communication, socialization, daily living skills, learning, play skills). The curriculum must be validated in the research literature and designed to assess skills, select treatment goals, and evaluate the member's progress multiple times within a year. Examples of commonly used criterion-referenced measures for ASD include the Verbal Behavior Milestones Assessment & Placement Program (VB-MAPP), the Assessment of Basic Language and Learning Skills (ABLLS), and the Early Start Denver Model (ESDM) Curriculum Checklist.

Treatment goals must be functional and individualized for the member. They must meet the following guidelines:

- Address assessed needs of the member.
- Be specific with clearly defined target behaviors.
- Be observable and measurable to allow frequent objective evaluation of progress.
- Include objective measures of baseline performance (e.g., frequency, rate, intensity, or duration of symptoms).
- Include clear, measurable mastery criteria.
- Be appropriate for the member's age and skill level.

Treatment goals should be achievable within the authorization period. For complex goals that require longer than a typical authorization period for mastery, providers should complete a task analysis of the planned treatment steps and include goals based on the individual treatment steps that can be achieved within a single authorization period.

For both comprehensive and focused treatment, the POC must include family members and other regular caregivers participating in various capacities and at different points during the course of treatment, with the goal of preparing caregivers to support member goals outside of treatment hours. Systematic, individualized caregiver training is encouraged to assist caregivers in becoming competent and confident at managing behavior and implementing treatment protocols across relevant real-life environments. Adequate training is generally not accomplished by simply having the caregiver present during treatment.

The POC must include a plan for involving the family in the member's treatment program (including frequency and modes). Measurable family goals may be included in the plan. Include accommodations for language and other communication barriers, if applicable.

Care Collaboration

Collaboration with other professionals helps ensure member progress by ensuring consistency of care. Treatment goals are most likely to be achieved when there is shared understanding and collaboration among all health care providers serving a member. In addition, requested services may not duplicate services delivered by other providers. See the Care Collaboration section of this *Update* for more information.

Every PA request must identify the individual on the member's team who directs communication and collaboration with other care providers serving the member.

The PA request must document efforts to collaborate with other service providers who may be working to achieve the same or similar goals. Planned communication may include, but is not limited to, record review, sharing POC, telephone or email check-ins, attendance at team meetings, or observation during therapy sessions. Providers are required to retain documentation of collaborative activities, which may include telephone logs, summaries of conversations or written communication, copies of POC, staffing reports, or received written reports.

Supporting Documents

Additional documents identified on the PA/BTA form may be required, depending on the specific PA request. When these documents are required, they must meet the following standards.

Prescription for behavioral treatment from a physician or medical professional authorized to prescribe. This must include the date of the prescription, the name and address of the member, the member's ForwardHealth identification number, the

service to be provided, the amount of service to be provided and the estimated length of time required (e.g., ____ hours/week x ____ months), the name and address of the prescriber, the prescriber's National Provider Identifier (NPI), and the prescriber's signature.

A prescription from a physician or medical provider must include the number of hours of services per week being prescribed. Medically necessary behavioral treatment services are covered as prescribed but do allow for variances not exceeding a total of 45 treatment hours per week. ForwardHealth allows flexible use of approved behavioral treatment services within these parameters to accommodate situations that would necessitate variances, such as inclement weather and illness of the member. If more hours are billed than what was prescribed and approved through the PA process, the provider's documentation must reflect the circumstances that indicate a need for additional time. Claims may be recouped for excessive billing with inadequate documentation.

Medication list. This must include current medication with dosages, the name of the physician or medical provider supervising the member's medication management, and the date of the last medication review.

Proposed schedule of treatment hours and school hours. This **must** be a proposed, grid-style weekly schedule for the member indicating the specific blocks of time when the member will be in school and in treatment. If the child is being homeschooled, this should indicate the blocks of time that the family intends to provide required educational programming each day. It should also include any regularly scheduled commitments, such as day care, outside therapies, or supportive services.

Most recent Birth to 3 Individual Family Service Plan (IFSP) or school Individualized Education Program (IEP). This must be the most recent plan that includes current intervention goals and a list of services that will be delivered during the requested authorization period.

Discharge criteria and transition plan. This must be the requesting treatment provider's standard discharge criteria that is refined throughout the member's treatment plan. Services should be reviewed and evaluated for discharge planning in the following situations:

- Member has achieved treatment goals.
- Member no longer meets diagnostic criteria for the condition being treated.
- Member has not demonstrated progress toward goals for successive authorization periods.
- Family wishes to discontinue services.
- Family and provider are unable to reconcile important issues in treatment planning and delivery.
- Member is frequently unable to participate effectively in treatment (e.g., due to medical issues).
- Sufficient skilled staff have been unavailable for three consecutive months, and provider cannot guarantee that the staffing shortage will be corrected within a month.
- Member requires an intervention approach or level of care that is not offered by the provider or is not commensurate with the provider's education, training, and experience.

Discharge criteria must be provided to ForwardHealth and the member at the outset of treatment. Clear indicators should be specified so that both families and PA request reviewers can easily recognize whether discharge criteria have been met.

Documentation Requirements

All of the following must be included as part of a PA request for behavioral treatment:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/13)
- A completed Prior Authorization/Behavioral Treatment Attachment (PA/BTA), F-01629 (12/2015)
- Documentation substantiating the request per the guidance provided in this *Update* and attachments
- A prescription for behavioral treatment from a physician or medical provider authorized to prescribe (Refer to the Supporting Documents section of this attachment for standards.)

Prior Authorization Criteria for Retroactive Medicaid Enrollment

If a service(s) that requires PA was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

For a PA request submitted on paper:

- At the top of the PA request, indicate the words "RETROACTIVE ENROLLMENT."
- Under "Description of Service," include a written description explaining that the service was provided at a time when the member was retroactively enrolled and include the actual date(s) the service(s) was provided.

For a PA request submitted via the ForwardHealth Portal, in the "Service Code Description" field, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable. The earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal denial of a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Approval Criteria for Prior Authorization Amendment Requests

A PA amendment request may be submitted to request an extension of services for up to a total of 12 months under the initial PA number. The following information is required to make a determination of medical necessity for a PA amendment request:

- Updated provider specialties on the behavioral treatment team, if applicable
- Updated POC
- Progress summary
- Documentation that was requested by ForwardHealth in the previous PA grant letter

Plan of Care

For comprehensive behavioral treatment, PA amendment requests must include an updated POC with the intended start and end dates for the authorization period, the intended treatment hours per week, and any planned modifications to treatment intensity. New treatment goals must be included in place of mastered goals.

For focused behavioral treatment, PA amendment requests must include an updated POC with the intended start and end dates for the authorization period, the intended treatment hours per week, and any planned modifications to treatment intensity. New treatment goals should not be included, although adjustments to the original goals may be appropriate to address barriers to progress. (Refer to “Lack of progress” in the Progress Summary section of this attachment for more information.)

Progress Summary

Prior authorization amendment requests must include a summary of the member’s progress, or lack of progress, since treatment was last authorized. The summary should include both narrative descriptions of behavior as well as measurements of current behavior compared to behavior at the beginning of the authorization period. Charts or data summaries of measurable results are acceptable. When standardized or other formal testing is included as part of a progress summary, include prior and current test results for comparison purposes.

For both comprehensive and focused treatment, members are expected to achieve a majority of treatment goals identified for each authorization period. For comprehensive treatment, mastery of goals is expected across a range of developmental areas (e.g., communication, socialization, daily living skills, learning, play skills). The provider is required to demonstrate that the member has mastered new skills and, therefore, has advanced or improved in function as a result of treatment intervention. Progress must be documented in specific, measurable, objective terms. Progress that is indicated by descriptive terms, such as “better,” “improved,” “calmer,” “less/more,” or “longer” are not measurable and will not be accepted by ForwardHealth.

Comprehensive treatment: Prior authorization amendment requests to extend comprehensive behavioral treatment may be approved if the treatment provider documents that the member has made adequate progress and that comprehensive behavioral treatment continues to be medically necessary.

In order to consider continuation of treatment at the current level of care, ForwardHealth requires a summary of the member’s current status or performance on the following:

- Mastery of skills from a research-validated, criterion-referenced measurement tool
- Progress toward treatment goals identified on the treatment plan
- Generalization of skills to new situations, settings, and partners outside of treatment sessions
- Gains in functional behavior that reduce the family’s reported stress and/or increase the member’s independence
- Measurable changes in the frequency, rate, intensity and/or duration of challenging behaviors

Because an important purpose of comprehensive treatment is to “close the developmental gap” between the member and same-age peers, ForwardHealth may require standardized age-normed assessments of the member’s progress toward developmental age norms in one or more of the following foundation skills areas:

- Cognitive functioning (e.g., IQ, developmental age equivalents)
- Communication skills (e.g., receptive and expressive language measures)
- Adaptive functioning (e.g., life skills, socialization, motor functioning, communication)

Age-normed testing is generally required by ForwardHealth but will not be requested more often than annually or more often than the tool’s administration protocol allows.

Focused treatment: Prior authorization amendment requests to extend focused behavioral treatment may be approved if the treatment provider documents that the member has not mastered the treatment goals but is making adequate progress and that behavioral treatment continues to be medically necessary. Because the purposes of focused treatment are to reduce challenging behavior and promote acquisition of discrete functional skills, progress is assessed by comparing baseline measures of behavior (e.g., frequency, rate, intensity, or duration of behaviors) or standardized assessments with post-treatment re-assessments on the same measures.

In order to consider continuation of treatment at the current level of care, ForwardHealth requires a summary of the member's current status or performance on the following:

- Measurable changes in the frequency, rate, intensity and/or duration of challenging behaviors
- Progress toward treatment goals identified on the treatment plan
- Generalization of skills to new situations, settings, and partners outside of treatment sessions

Lack of progress: If the member has made limited or no progress by the end of the authorization period, ForwardHealth will only consider PA amendment requests for behavioral treatment that clearly identify barriers to progress and propose a corrective action plan, which will be evaluated as part of the PA request approval process. The corrective action plan must include the following:

- Identification of barriers to progress
- Description of corrective actions that have been attempted
- Completion of a functional behavior analysis, as appropriate
- Consultation with other professional specialties (e.g., psychiatry) as appropriate
- Updated plan for family education and participation
- A proposed plan of action that addresses the barriers and/or revises the treatment goal(s), including a rationale for continued treatment at the level of service requested

If ForwardHealth concludes that the corrective action plan is inadequate or that medical necessity has not been adequately demonstrated, the PA amendment request will be denied. ForwardHealth may authorize a transition to other medically necessary services.

Documentation Requirements

All of the following must be included as part of a PA amendment request for behavioral treatment:

- A completed Prior Authorization Amendment Request, F-11042 (07/12)
- Documentation substantiating the request as previously outlined
- An updated prescription from a physician or medical provider if the previous prescription has expired, or will expire during the authorization period, or if requesting an increased level of service

Approval Criteria for Subsequent Prior Authorization Requests

A subsequent PA request may be submitted to continue comprehensive behavioral treatment beyond the initial 12 months or to request a new episode of focused behavioral treatment with a new set of treatment goals. The following information is required to make a determination of medical necessity for a subsequent PA request:

- Diagnostic evaluation (provide updated information, if available)
- Provider's initial assessment (focused treatment only)

- Previous treatment history (provide updates, including completed courses of focused treatment)
- Medical evaluation
- Standardized testing (provide updated test results, if available)
- Behavioral treatment team (if there are changes in the provider specialties composing the team)
- New or updated POC
- Progress summary (comprehensive treatment only)
- Care collaboration plan (provide updates, if any)
- Supporting documents

Provider's Initial Assessment

For focused treatment, the provider may submit either the original initial assessment with an addendum that summarizes updates and changes in the member's condition, or a new initial assessment. See the Approval Criteria for Initial PA Requests section of this attachment for additional details.

Medical Evaluation

The member must have completed a comprehensive medical examination no more than 12 months prior to the submission of the subsequent PA request. Medical examinations for members younger than age 21 must comply with HealthCheck screening guidelines. Refer to the HealthCheck (EPSDT) service area of the Online Handbook for additional information.

Plan of Care

Subsequent PA requests must include an updated POC with the intended start and end dates for the authorization period, the intended treatment hours per week, and any planned modifications to treatment intensity. New treatment goals must be included in place of mastered goals.

Progress Summary

Subsequent PA requests must include a summary of the member's progress, or lack of progress, since comprehensive treatment was last authorized. Refer to the Approval Criteria for Prior Authorization Amendment Requests section of this attachment for additional details.

Supporting Documents

Additional documents identified on the PA/BTA form may be required, depending on the specific PA request. When these documents are required, they must meet the following standards.

Prescription for behavioral treatment from a physician or medical professional authorized to prescribe. This must be an updated prescription. Refer to the Approval Criteria for Initial Prior Authorization Requests section of this attachment for additional details.

Medication list. This must be an updated list of current medication with dosages, the name of the medical provider supervising the member's medication management, and date of last medication review.

Proposed schedule of treatment hours and school hours. This must be an updated grid-style weekly schedule for the member indicating the specific blocks of time when the member will be in school and in treatment. Refer to the Approval Criteria for Initial Prior Authorization Requests section of this attachment for additional details.

Most recent Birth to 3 IFSP or school IEP. This must be the most recent plan that includes current intervention goals and a list of services that will be delivered during the requested authorization period.

Discharge criteria and transition plan. This must be an updated transition plan based on the member's progress in treatment. Refer to the Approval Criteria for Initial Prior Authorization Requests section of this attachment for additional details.

Documentation Requirements

All of the following must be included as part of a subsequent PA request for behavioral treatment:

- A completed PA/RF
- A completed PA/BTA
- Documentation substantiating the request per the guidance provided in this *Update* and Attachments
- A prescription for behavioral treatment from a medical provider (Refer to the Supporting Documents section of this attachment for standards.)

ATTACHMENT 3

Prior Authorization Request Form (PA/RF)

Completion Instructions for Behavioral Treatment Services

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

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

Under Wis. Stat. § 49.45(4), 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 the Prior Authorization Request Form (PA/RF), F-11018, is mandatory to receive PA for certain 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 the PA/RF and other required documentation via the ForwardHealth Portal, by fax to ForwardHealth at 608-221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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"

Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the PA/RF are for HealthCheck "Other Services." The provider is required to select HealthCheck "Other Services" when requesting comprehensive behavioral treatment.

Element 2 — Process Type

Enter process type "142" for behavioral treatment. The process type is a three-digit code used to identify a category of service requested.

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 Medicaid-enrolled behavioral treatment provider's name and complete address (street, city, state, and ZIP+4 code). 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 Medicaid-enrolled behavioral treatment provider's 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.

Element 6a — Name — Prescribing/Referring/Ordering Provider

Enter the prescribing medical provider's name. This is the name of the Medicaid-enrolled medical provider writing the prescription for behavioral treatment.

Element 6b — National Provider Identifier — Prescribing/Referring/Ordering Provider

Enter the prescriber's 10-digit NPI. The NPI in this element must correspond with the provider's name listed in Element 6a.

SECTION II — MEMBER INFORMATION

Element 7 — 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 8 — Date of Birth — Member

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

Element 9 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code.

Element 10 — 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 11 — Gender — Member

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

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases* (ICD) diagnosis code and description with the greatest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (not required)

Element 14 —First Date of Treatment — (not required)

Element 15 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD diagnosis code and description with the greatest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — Requested PA Start Date

Enter the requested start date for service(s) in MM/DD/CCYY format.

Element 17 — Rendering Provider Number

Enter the NPI of the provider who will be performing the service, **only** if the NPI is different from the NPI of the billing provider listed in Element 5a. The rendering provider is required to be a Medicaid-enrolled behavioral treatment provider.

Element 18 — Rendering Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, **only** if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 19 — Service Code

Enter the appropriate *Current Procedural Terminology* (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code for each service/procedure/item requested using the procedure code set that is allowable for the member's **primary insurance**.

If the member has Medicaid only (including Medicaid HMO only), the allowable procedure code is 0365T (Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time).

To simplify the PA submission process, providers may request all direct treatment units for CPT codes 0364T, 0365T, 0366T, 0367T, 0368T, and 0369T by including the cumulative total of requested treatment units as a single line item, using a single code (0365T). Claims submitted using any of these CPT codes will be decremented against the cumulative total of approved treatment units.

Family Adaptive Behavior Treatment Guidance

Family adaptive behavior treatment guidance services must be requested as a separate line item on the PA/RF using CPT procedure code 0370T.

Team Meeting

Team meeting services must be requested on a separate line item on the PA/RF using CPT procedure code 0370T.

Element 20 — Modifiers

Enter the modifier corresponding to the level of service requested using the modifiers required by the member's **primary insurance**.

If the member has Medicaid only (including Medicaid HMO only), use the following modifier(s):

- Comprehensive Behavioral Treatment (modifier TG).
- Focused Behavioral Treatment (modifier TF).
- Team Meeting (modifier AM). Modifier AM is used **only** with procedure code 0370T when 0370T is used to indicate team meetings. Do **not** use modifier AM with procedure code 0370T when it is used to indicate family adaptive treatment guidance.

Element 21 — POS

Enter the appropriate place of service (POS) code designating where the requested service would be provided. If the service is provided in more than one place, the provider should list the POS code that reflects the place that the majority of service will be provided.

Element 22 — Description of Service

Enter a written description of the allowable procedure code that corresponds to the procedure code listed in Element 19 for each service requested. Also indicate **the number of weeks** for which the service is requested.

Element 23 — QR

Enter the appropriate quantity (e.g., number of units) requested for the procedure code listed in Element 19.

Element 24 — Charge

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity requested (Element 23) is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter the 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 25 — Total Charges

Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider

The original signature of the provider (first and last name) requesting this service must appear in this element.

Element 27 — Date Signed

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

ATTACHMENT 4

Prior Authorization Request Form (PA/RF) Sample for Behavioral Treatment Services

A sample of a completed Prior Authorization/Request Form (PA/RF), F-11018 (05/13), is located on the following page. The information presented in this sample is for illustrative purposes only and does not constitute guidance from ForwardHealth regarding specific entries that a provider should make on a PA/RF for a specific PA request for a specific member.

Comprehensive Behavioral Treatment Sample

Scenario: A provider requests comprehensive behavioral treatment for a member. Treatment is requested in the home for 26 weeks at an intensity of 34 hours/week of face-to-face treatment. Family guidance is requested for one time per month, in the home, for 26 weeks. The treatment therapist conducts a team meeting once per week in the home for 26 weeks.

**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, 313 Blettner Boulevard, Madison, WI 53784. **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 <input checked="" type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)			2. Process Type 142		3. Telephone Number — Billing Provider (555) 555-5555					
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN, WI 55555-1234					5a. Billing Provider Number 022222220					
					5b. Billing Provider Taxonomy Code 123456789X					
6a. Name — Prescribing / Referring / Ordering Provider I.M. ORDERING PROVIDER					6b. National Provider Identifier — Prescribing / Referring / Ordering Provider 0333333330					
SECTION II — MEMBER INFORMATION										
7. Member Identification Number 1234567890			8. Date of Birth — Member MM/DD/CCYY			9. Address — Member (Street, City, State, ZIP Code) 322 RIDGE ST ANYTOWN, WI 55555				
10. Name — Member (Last, First, Middle Initial) MEMBER IM, A			11. Gender — Member <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female							
SECTION III — DIAGNOSIS / TREATMENT INFORMATION										
12. Diagnosis — Primary Code and Description XXXX-XXXXXXXXXXXXXXXXXXXX					13. Start Date — SOI		14. First Date of Treatment — SOI			
15. Diagnosis — Secondary Code and Description					16. Requested PA Start Date MM/DD/CCYY					
17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers				21. POS	22. Description of Service	23. QR	24. Charge
			1	2	3	4				
044444440	123456789X	0365T	TG				12	Adaptive behavior treatment, 26 wks	1768	XXXX.XX
044444440	123456789X	0370T	TG				12	Family guidance, 26 wks	6	XXXX.XX
044444440	123456789X	0370T	TG	AM			12	Team meeting, 26 wks	26	XXXX.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.									25. Total Charges	XXXX.XX
26. SIGNATURE — Requesting Provider <i>I. M. Provider</i>									27. Date Signed MM/DD/CCYY	



DT-PA049-049

ATTACHMENT 5

Prior Authorization/Behavioral Treatment Attachment (PA/BTA) Completion Instructions

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

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**FORWARDHEALTH
PRIOR AUTHORIZATION / BEHAVIORAL TREATMENT ATTACHMENT (PA/BTA)
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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stats. § 49.45(4), 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 behavioral treatment. 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 reasonable judgment about the case.

Each provider is required to submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the member to meet ForwardHealth's definition of "medically necessary." "Medically necessary" is defined in Wis. Admin. Code § DHS 101.03(96m). Each PA request is unique, representing a specific clinical situation at a specific point in time. Providers typically consider a number of issues that influence a decision to proceed with behavioral treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. ForwardHealth's clinical consultants will consider documentation of those same factors to determine whether or not the request meets ForwardHealth's definition of "medically necessary." ForwardHealth's consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

These directions are formatted to correspond to each required element on the Prior Authorization/Behavioral Treatment Attachment (PA/BTA), F-01629. The **bold** headings directly reflect the name of the element on the PA/BTA.

Attach the completed PA/BTA 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 via the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/>, by fax to 608-221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

INSTRUCTIONS

The PA/BTA form is designed to be used for all types of behavioral treatment PA requests. Not all sections of the PA/BTA form will be completed for every PA request. Follow the instructions on the form and in these instructions to determine which sections to complete. Where noted on the form and in these instructions, the provider may attach material from the member's records.

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 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format (e.g., 02/14/2014).

Element 3 — Member Identification Number

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

SECTION II — SERVICE REQUEST

Element 4

Check the appropriate box on the PA/BTA for the type of behavioral treatment service being requested.

Initial vs. subsequent pertains to Medicaid PA requests made by the requesting provider for this member. If services have been requested for the member from a different funding source (e.g., commercial insurance) or by a different provider (e.g., the member has received behavioral treatment elsewhere), but this is the requesting provider's first request to Medicaid for the member, indicate "initial."

If the provider has submitted previous PA requests for one service but is making a first request for the other type of service, indicate that the request is an initial request for the new type of service. For example, if the provider has submitted previous requests for Comprehensive Treatment on behalf of the member but is now submitting a first request for Focused Treatment, check "Initial PA — Focused" on the form.

SECTION III — DIAGNOSTIC EVALUATION

Element 5

Indicate whether or not diagnostic information for the member was submitted with a prior PA request for the member. If diagnostic information was submitted with a prior PA, include the prior PA number. If not, skip to Element 7.

Element 6

Indicate whether or not a new diagnostic evaluation has been completed since the prior PA. If a new diagnostic evaluation has been completed since the prior PA, continue to Element 7 to include the updated diagnostic information. If the member's diagnosis has not been formally re-evaluated, skip the remainder of Section III and go to Element 11 in Section IV.

Element 7

Include details — the date, the provider's name, and diagnosis codes — about all prior diagnostic evaluations related to the member's developmental status and behavior. This should include the member's current diagnosis, for which the member is currently seeking behavioral treatment, as well as all prior diagnostic evaluations, whether or not the prior diagnosis matches the current diagnosis. Enter diagnostic code numbers in the spaces provided. Attach additional sheets, if needed, to include all previous diagnostic evaluations.

Include copies of all current and past diagnostic reports. In situations where multiple or competing diagnoses have been given, the current diagnostic report should address the alternate diagnoses and include details about developmental and/or medical evaluations that contributed to the differential diagnosis.

Note: A PA request may be returned if updated diagnostic documentation is not provided and other documentation suggests there have been changes to the member's condition/needs that may indicate a need for diagnostic re-evaluation. Providers are expected to verify that the member's diagnosis continues to be accurate. Refer to the ForwardHealth Online Handbook for guidelines on diagnostic standards.

Element 8

If the requesting provider conducted the member's diagnostic assessment, indicate whether or not the provider consulted with another professional regarding diagnosis or treatment. For the purposes of this element, consultation may include referring the member to see another diagnostician, a conversation, or electronic correspondence with another professional. Although record reviews are expected as part of the diagnostic process, a record review does not constitute consultation.

Element 9

Provide the name of the other professional with credentials, date of consultation, and results. Results of the consultation may be reported as "diagnosis confirmed" or a diagnostic code number may be included. If more detailed information is available, write "see attached" and include a brief summary or a consultation report with this request.

Element 10

Indicate whether or not a copy of the consultation report will be included with this PA request.

SECTION IV — PREVIOUS TREATMENT

This section includes information about treatments previously received by the member that are related to the member's current deficits, including, but not limited to, behavioral treatment, speech therapy, occupational therapy (OT), physical therapy, daily living skills training, and psychotherapy. Other treatment that is currently in progress should be documented in Section X of the PA/BTA.

Element 11

If details of the member's previous treatment were submitted with a prior PA, include the prior PA number. If not, skip to Element 13.

Element 12

If the member has **completed** any type of treatment since the prior PA, continue to Element 13 and include updated details. Do not repeat information that was reported on the prior PA listed in Element 11.

If the member has not completed any treatment since the prior PA, skip the remainder of Section IV and go to Element 14 in Section V of the PA/BTA.

Element 13

Summarize previous episodes of treatment in the table provided in this section based on history taken from the member, member's caregivers, or the member's file. Attach additional sheets if needed.

For the Results/Effectiveness field, provide a summary evaluation that indicates the member's response to the intervention, such as "effective," "moderately effective," or "ineffective." If the results were more complex and are summarized elsewhere in the PA request, indicate this (e.g., "see Initial Assessment").

For the Reason for Discontinuing field, provide a summary explanation, such as "aged out" (i.e., Birth to 3), "family relocated," or "discharged-goals mastered."

SECTION V — MEDICAL EVALUATION

The requesting provider is required to seek information from the member's medical provider regarding specific facets of the member's health that might impact the member's participation and/or expected outcomes from behavioral treatment.

All of the information in this section must be complete and accurate. The requesting provider is required to maintain on file written, signed, and dated documentation from the member's medical provider, attesting to the member's current physical health with regard to each item detailed in this section. **Incomplete information in Section V will result in a returned PA request.**

Note: Section V of the PA/BTA has been designed so that providers may send the page directly to the member's medical provider, if desired. However, requesting providers may elect to obtain this medical information in a different format. The medical provider's signature and date fields at the bottom of the page are not required for the PA request; they are included for the convenience of requesting providers who may elect to include this page in the member's file to comply with the Department of Health Services' documentation requirements.

Most Recent Medical Exam (Elements 14–16)

Element 14 — Date of Exam

Enter the date of the member's most recent medical examination. Medical examinations for members under 21 years of age must comply with HealthCheck screening guidelines. Medical examinations must have occurred no more than 12 months prior to the requested start date for treatment services.

Element 15 — Name — Provider

Enter the first and last name of the medical provider who conducted the member's medical examination.

Element 16 — Provider's National Provider Identifier

Enter the medical provider's National Provider Identifier.

Element 17

Provide findings from hearing and vision screenings. Formal testing is not required if the screening indicates functioning within normal limits. If additional testing was indicated or performed, provide a brief summary of the details. If more space is required, attach additional sheets or provide a copy of the test results.

Indicate whether genetic testing was completed and whether abnormalities were identified. Provide a brief summary of the findings. If abnormalities were noted, include a copy of test results.

Indicate the medical provider's findings regarding the member's physical health for each item on the form. When "no concerns" is selected, no further details are required. When concerns are noted for any medical issue, provide dates for follow-up tests, indicate whether or not medication trials were attempted and a brief summary of results. If more space is required, attach additional sheets.

Element 18

Indicate whether or not the member regularly takes prescription medications. If so, provide a list of current medications, including the name of the medical provider managing the medications and the date of the last medication check.

SECTION VI — STANDARDIZED TESTING

Element 19

Document the most recent standardized and functional behavior assessments that have been conducted. Indicate whether the assessment was completed to establish the member's baseline prior to treatment or to evaluate progress.

Providers should submit all recent standardized test results or functional behavior assessments with this PA request. Progress evaluations should include prior and current results for comparison purposes.

Element 20

If other formal testing has been completed, provide details in the spaces provided on the PA/BTA. Providers should submit test results with this PA request.

SECTION VII — TREATMENT TEAM

This section includes information about direct service (face-to-face) hours that are recommended for this member, as well as the frequency and method of supervision of unlicensed staff. Hours formally requested for each billing code are detailed on the PA/RF. The hours reported in this section clarify which type of staff member(s) will be the primary service provider(s). Treatment team members do **not** need to be identified by name in this section. Although exceptional circumstances may occasionally result in changes to the treatment schedule, for the purposes of this section, document recommended hours during a typical week. It is not essential that the hours on the PA/RF match the hours on the PA/BTA.

Element 21

In the Direct Service Hours column, enter the number of direct service hours recommended in the member's plan of care (POC) for each type of staff. Direct service includes face-to-face service that is provided to the member.

Indicate the number of hours the licensed supervisor plans to have face-to-face contact with the member — either weekly, monthly, or every-other-month (EOM) — according to the recommended treatment plan.

Within each staff category, indicate the total number of recommended face-to-face hours to be provided each week. For example, if a treatment team has one treatment therapist who provides five hours of service per week (either face-to-face with the member or supervising technicians while they serve the member) and four treatment technicians who each work eight hours per week, include five hours of treatment therapist direct service and 32 hours of treatment technician direct service (4 staff x 8 hours per person).

For unlicensed staff (therapists and technicians), provide details about the number of hours staff are supervised, how supervision is provided (e.g., one-on-one coaching, team meetings), and by whom. Attach additional sheets if needed or refer to the POC if it describes the supervision protocol.

Element 22

If the member is a dual-language learner, describe the team's training and accommodations to address language barriers. Indicate the primary language that will be used during therapy activities, particularly for language learning activities. Document any specialized training or skills required for team members who will be serving dual language learners. Document the plan for the family to practice language learning activities outside sessions, if the primary language used during treatment is not the parents' first spoken language.

SECTION VIII — POC

Element 23

Identify the treatment approach/protocol to be used.

Element 24

Describe the member's treatment goals for the requested time period.

Element 25

Describe the plan for involving the family in the member's treatment program (including frequency and modes) for the requested time period.

SECTION IX — PROGRESS SUMMARY

Element 26

Describe the member's general progress, or lack of progress, since treatment was last authorized. This should be a brief narrative overview that addresses signs of overall changes in functioning compared to the beginning of the authorization period. This summary may include impressions reported by the member, the member's family, team members, and/or the supervising professional.

Element 27

Describe measurable progress toward goals since treatment was last authorized in specific, objective terms, using consistent units of measurement that compare functioning at the beginning and end of the authorization period. Include details on both member goals and family goals. If charts or data summaries are included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided on the form.

Element 28

For a member who has made limited progress by the end of the authorization period, identify the barriers to progress and document the proposed corrective action plan.

If a plan of corrective action is included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided on the form.

SECTION X — CARE COLLABORATION

List other providers who are currently serving the member. If no other providers are currently serving the member, indicate "not applicable" in the space provided. Document the collaboration with other service providers who may be working to achieve the same, or similar, goals for the member. Planned communication and care collaboration may include activities including, but not limited to, record review, sharing POC, telephone or email check-ins, attendance at team meetings, or observation during therapy sessions. Providers are required to retain documentation of care collaboration efforts, which may include telephone logs, summaries of conversations or written communication, copies of POC, staffing reports, or received written reports.

Element 29

Document planned communication and collaboration with other professionals who are concurrently providing services using the spaces provided in A-F of the PA/BTA or an attachment:

- A. Provide the name and title of the individual within the provider's agency who is responsible for care collaboration for the member. This is the individual who serves as the primary contact with other care providers.
- B. Provide the name of the county and county contact person(s). Include details about any county-funded services the member is receiving or is expected to receive during the authorization period, including services and supports under the Children's Long-Term Support Waiver or other Medicaid waivers. Document the plan for the method(s) and frequency of communication with this agency regarding the member's progress and care needs. If the member has no current services through the county, write "none."
- C. Provide the name of the Birth to 3/Early Intervention provider agency and contact person(s). Include details about services the member is currently receiving or is expected to receive during the authorization period. Provide details about the frequency of each intervention (e.g., speech and language pathology [SLP], 2 30-minute sessions per week; OT, 1 60-minute session per week). Document the plan for the method(s) and frequency of communication with this agency regarding the member's progress and care needs. If the member is in the Birth to 3 Program, submit the Individualized Family Service Plan (IFSP) or, if in a school setting, provide the most recent Individual Education Program (IEP). If the member has no current services through Birth to 3/Early Intervention, write "none."
- D. Provide the name of the member's school and contact person(s). Include details about services the member is currently receiving or is expected to receive during the authorization period. Provide details about the frequency of each intervention (e.g., Early Childhood classroom, 11 hours per week; SLP, 1 hour per week). Document the plan for the method(s) and frequency of communication with school personnel regarding the member's progress and care needs. If the member is not enrolled and/or has no current services through school, write "none."
- E. Indicate the type of outside therapy (e.g., SLP, OT) the member receives. Do not include therapies provided through Birth to 3 or the school district. Provide the agency name and contact person(s). Include details about services the member is currently receiving or is expected to receive during the authorization period. Provide details about the frequency of the intervention. Document the plan for the method(s) and frequency of communication with this agency regarding the member's progress and care needs. If the member is not enrolled and/or has no current outside therapies, write "none."
- F. Indicate the type of other service the member receives. This may be an additional outside therapy or a service not otherwise identified in this section. Provide the agency name and contact person(s). Include details about services the member is currently receiving or is expected to receive during the authorization period. Provide details about the frequency of the intervention. Document the plan for the method(s) and frequency of communication with this agency regarding the member's progress and care needs. If the member is not receiving outside services, write "none."

SECTION XI — ATTACH SUPPORTING DOCUMENTATION

Element 30

For **initial** PA requests, attach and label all of the following documents, and include the member name and member ID on each document:

- a. Medical provider's prescription for behavioral treatment services
- b. Medication list, if applicable (Include medication name and dosage, prescriber, and date of last medication review by the prescriber.)
- c. Comprehensive psychological or neuropsychological diagnostic report
- d. Developmental and/or medical evaluation reports that contributed to the differential diagnosis
- e. Provider's initial assessment of member's functional skills, limitations, and treatment needs (Include a copy of the provider's initial assessment of the member, completed prior to the initiation of treatment for the current problem being treated.)
- f. Standardized assessments of baseline functioning and/or progress related to treatment
- g. Proposed schedule of treatment hours and school hours for members in school or being homeschooled (Include a proposed weekly schedule for the member, indicating the specific blocks of time when the member will be in school and in treatment. If the child is being homeschooled, indicate the blocks of time that the family intends to provide required educational programming each day. Also include any regularly scheduled commitments, such as day care or outside therapies.)
- h. Most recent Birth to 3 IFSP or school IEP (Include the most recent plan that includes current intervention goals and a list of services. If standardized testing was completed, these results should be included under item f of Element 30.)
- i. Plan of care (unless fully summarized in Section VIII of the PA/BTA form)
- j. Discharge criteria and transition plan

Element 31

For **subsequent** PA requests, attach and label all of the following documents, and include the member name and member ID on each document:

- a. Updated medical provider's prescription for behavioral treatment services (if prescription will expire before the end of the PA period)
- b. Updated medication list (if any)
- c. Updated psychological or neuropsychological diagnostic reports (if any)
- d. Updated standardized assessments of progress related to treatment (if any)
- e. Updated Birth to 3 IFSP or school IEP (if any)
- f. Proposed schedule of treatment hours and school hours for members in school or being homeschooled
- g. Summary of progress related to treatment goals (unless fully summarized in Section IX of the PA/BTA form)
- h. Updated POC (unless fully summarized in Section VIII of the PA/BTA form)
- i. Discharge criteria and transition plan

SECTION XII — SIGNATURE

Element 32 — SIGNATURE — Licensed Professional

The signature of the Medicaid-enrolled behavioral treatment provider, who must be a licensed professional, is required at the end of the PA/BTA.

Element 33 — Credentials

Enter the credentials of the person who signed in Element 32 (e.g., Ph.D.).

Element 34 — Date Signed

Enter the month, day, and year the PA/BTA was signed (in MM/DD/CCYY format) by the licensed professional.

Element 35 — Name — Licensed Professional (Print)

Include the printed name of the Medicaid-enrolled behavioral treatment provider, who must be a licensed professional.

ATTACHMENT 6

Prior Authorization/Behavioral Treatment Attachment (PA/BTA)

(A copy of the “Prior Authorization/Behavioral Treatment Attachment [PA/BTA]” is located on the following pages.)

(This page was intentionally left blank.)

FORWARDHEALTH
PRIOR AUTHORIZATION / BEHAVIORAL TREATMENT ATTACHMENT (PA/BTA)

Instructions: Type or print clearly. Before completing this form, refer to the Prior Authorization/Behavioral Treatment Attachment (PA/BTA) Completion Instructions, F-01629A. Providers may submit prior authorization (PA) requests to ForwardHealth via the ForwardHealth Portal, by fax at 608-221-8616, or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

SECTION I — MEMBER INFORMATION

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

2. Date of Birth — Member

3. Member Identification Number

SECTION II — SERVICE REQUEST

4. Check One

☐ Initial PA — Comprehensive

☐ Subsequent PA — Comprehensive

☐ Initial PA — Focused

☐ Subsequent PA — Focused

SECTION III — DIAGNOSTIC EVALUATIONS (Complete this section for all initial PA requests. For subsequent PAs, provide an updated diagnosis, if available.)

5. Was diagnostic information submitted with a prior PA?

☐ Yes. Enter the PA number _____

☐ No. Skip Element 6 and go to Element 7.

6. Has a new diagnostic evaluation been completed since the prior PA?

☐ Yes. Continue to Element 7.

☐ No. Skip the remainder of Section III and go to Section IV, Element 11.

7. Document the chronological history of diagnostic evaluations related to the member's developmental status and behavior. Attach copies of all diagnostic reports, including developmental and/or medical evaluations that contributed to the differential diagnosis. Attach additional sheets if needed to include all previous diagnostic evaluations.

Date	Name — Provider	Primary Diagnosis Code	Additional Diagnosis Code(s)

8. If the requesting provider conducted the diagnostic assessment, has the provider consulted with another professional regarding diagnosis or treatment?

☐ Yes — continue to Element 9.

☐ No — skip Elements 9–10, go to Section IV, Element 11.

☐ Not applicable — member received independent diagnosis; skip Elements 9–10, go to Section IV, Element 11.

9. Provide the name of the other professional with credentials, date of consultation, and results in the spaces provided.

Name — Professional	Credentials	Date of Consultation
---------------------	-------------	----------------------

Results

10. Will a copy of the consultation report be included with this PA request?

☐ Yes

☐ No

Continued



DT-PA113-113

SECTION IV — PREVIOUS TREATMENT (Complete this section for all initial PA requests. For subsequent PAs, provide updates as needed.)

11. Were details about the member's previous treatment experience submitted with a prior PA?

- ☐ Yes. Provide the PA number _____
- ☐ No. Skip Element 12 and go to Element 13.

12. Has the member recently completed any types of treatment not previously documented on the prior PA?

- ☐ Yes. Continue to Element 13. Provide updated details. (Do not repeat previously reported information.)
- ☐ No. Skip Element 13 and continue to Section V, Element 14.

13. Document the chronological history of treatment by all past service providers related to the member's current deficits and maladaptive behaviors, dates of those treatments, effectiveness, and the reason the treatment was discontinued. If the member has had no previous treatment, write "none." Attach additional sheets if needed.

A	Type of Treatment	Start Date (MM/YY)	End Date (MM/YY)
Name of Agency, City / State		Name — Person Who Supervised Treatment	

Results / Effectiveness

Reason for Discontinuing

B	Type of Treatment	Start Date (MM/YY)	End Date (MM/YY)
Name of Agency, City / State		Name — Person Who Supervised Treatment	

Results / Effectiveness

Reason for Discontinuing

C	Type of Treatment	Start Date (MM/YY)	End Date (MM/YY)
Name of Agency, City / State		Name — Person Who Supervised Treatment	

Results / Effectiveness

Reason for Discontinuing

D	Type of Treatment	Start Date (MM/YY)	End Date (MM/YY)
Name of Agency, City / State		Name — Person Who Supervised Treatment	

Results / Effectiveness

Reason for Discontinuing

Continued

SECTION V — MEDICAL EVALUATION (Complete this section for all initial PAs. For subsequent PAs, only include annual updates [every 12 months after the initial PA].)

Name — Member		Member's Date of Birth	
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Most Recent Medical Exam	14. Date of Exam	15. Name — Provider	16. Provider's National Provider Identifier
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17. Provide details about the medical professional's examination and evaluation of the member's physical health in the spaces provided.

Hearing and Vision		Complete only for abnormal findings.	
		Date of Follow-up Test	Results or Comments
Audiology Screen	<input type="checkbox"/> Within Normal Limits		
	<input type="checkbox"/> Outside Normal Limits		
Vision Screen	<input type="checkbox"/> Within Normal Limits		
	<input type="checkbox"/> Outside Normal Limits		

Genetic Testing	Reason	Details About Abnormal Findings
Genetic Testing (e.g., chromosomal microarray, Fragile X)	<input type="checkbox"/> Completed — No Abnormalities <input type="checkbox"/> Completed — Abnormalities Noted <input type="checkbox"/> Not Completed — No Concerns <input type="checkbox"/> Not Completed — Other Reason	

Medical Issue	Findings	Complete only when concerns are noted.		
		Date of Follow-up Test	Medication Trials?	Results or Comments
Seizure Disorder	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Attention Problems	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Sleep Concerns	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Digestion Problems	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Elimination Problems	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Nutrition Concerns	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Depression Concerns	<input type="checkbox"/> No Concerns <input type="checkbox"/> Concerns Noted			
Other Concern	List Area of Concern			

18. Does the member regularly take prescription medication(s)?

- ☐ Yes. Submit a current medication list with this PA request with the date of last medication check.
☐ No.

If the provider has printed this form to collect medical information from the member's medical provider, have the medical provider sign and date the form and keep it as part of the member's file.

Name — Medical Provider (Print)	SIGNATURE — Medical Provider	Date Signed
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Continued

SECTION VI — STANDARDIZED TESTING (Complete this section for all initial PA requests. For subsequent PAs, only include updates since the last PA request.)

19. Document the most recent standardized and functional behavior assessments that have been conducted. Indicate whether the assessment was completed to establish the member's baseline prior to treatment or to evaluate progress. Submit all recent standardized test results with this PA request. Progress evaluations should include prior and current results for comparison purposes.

Assessment Type	Requirements	Date of Assessment	Purpose	Tool(s) Used
Cognition / Mental Age	Age-Normed Results Required for Comprehensive		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	
Communication	Age-Normed Results Required for Comprehensive		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	
Daily Living Skills, Socialization, Motor Skills	Age-Normed Results Required for Comprehensive		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	
Functional Behavior Assessment	Required for Aggression, Destructive Behavior, Self-injury		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	
Standardized Assessments of Skill Limitations	Required for Focused		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	

20. If other formal testing has been completed, provide details in the space provided. Submit test results with this PA request.

Assessment Type	Date of Assessment	Purpose	Tool(s) Used
		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	
		<input type="checkbox"/> Baseline <input type="checkbox"/> Progress	

SECTION VII — TREATMENT TEAM (Complete this section for all initial and subsequent PA requests.)

21. Enter the frequency of planned service provided directly to the member by each type of staff and the frequency and method of supervision for all unlicensed staff. If details of the supervision protocol are described in the plan of care (POC), enter "see attached."

Staff Type	Direct Service Hours (Indicate per Week or Month)	Supervision (Hours per Week, Method, by Whom)
Licensed Supervisor		N/A
Treatment Therapist		
Treatment Technician		

22. If the member is a dual-language learner, describe the team's training and accommodations to address language barriers.

Continued

SECTION VIII — POC (Complete this section for all initial and subsequent PA requests.)

23. Identify the treatment approach / protocol to be used.

24. List the specific, objective, and functional goals for the member, to be met by the end of the authorization period. Goals must include measurable criteria for assessing progress and mastery. If the POC with detailed goals is included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided.

25. Describe the plan for involving the family in the member's treatment program (including frequency and modes). Measurable family goals may be included in the plan. Include accommodations for language and other communication barriers, if applicable. If a plan for family involvement is included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided.

SECTION IX — PROGRESS SUMMARY (Complete this section for all subsequent PA requests and for initial requests for members who are already receiving treatment.)

26. Describe the member's general progress, or lack of progress, since treatment was last authorized. Comment on signs of overall improved functioning compared to the beginning of the authorization period. If a general progress summary is included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided.

27. Since treatment was last authorized, describe measurable progress toward goals in specific, objective terms, using consistent units of measurement that compare functioning at the beginning and end of the authorization period. Include details on both member goals and family goals. If charts or data summaries are included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided.

28. If the member has made limited progress, identify barriers to progress. Describe corrective actions that have been attempted, complete a functional behavior analysis (as appropriate), and include details of consultations with other specialties (e.g., occupational therapy, psychiatry). Propose a plan of action to address the identified barriers and a rationale for ongoing treatment at the level of service requested. If a plan of corrective action is included in other documentation prepared for the member's records, attach a copy and enter "see attached" in the space provided.

SECTION X — CARE COLLABORATION (Complete this section for all initial and subsequent PA requests.)

29. Document planned communication and collaboration (e.g., meetings, telephone conferences, document reviews) with other professionals who are concurrently providing services using the form below or via an attachment. If the member is in the Birth to 3 Program, submit the Individualized Family Service Plan (IFSP) or, if in a school setting, provide the most recent Individual Education Program (IEP). If the member has no current service providers, write "none."

A	Requesting Provider's Agency	Name and Title — Care Collaborator
B	County Waiver Agency	Names — County and Team Members

Current Services Provided

Frequency of Interventions

Method and Frequency of Care Collaboration

C	Birth to 3 / Early Intervention	Names — Agency and Team Members
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Current Services Provided

Frequency of Interventions

Method and Frequency of Care Collaboration

D	School District	Names — School District and Team Members
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Current Services Provided

Frequency of Interventions

Method and Frequency of Care Collaboration

E	Outside Therapy	Names — Agency and Team Members
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Current Services Provided

Frequency of Interventions

Method and Frequency of Care Collaboration

F	Other	Names — Agency and Team Members
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Current Services Provided

Frequency of Interventions

Method and Frequency of Care Collaboration

Continued

SECTION XI — ATTACH SUPPORTING DOCUMENTATION

30. For **initial** PA requests, attach and label all of the following documents, and include the member name and member ID on each document:

- a. Medical provider's prescription for behavioral treatment services, including hours per week and number of months, dated not more than six months prior to the requested start date
- b. Medication list, if the member takes regular medications
- c. Comprehensive psychological or neuropsychological diagnostic report
- d. Developmental and/or medical evaluation reports that contributed to the differential diagnosis
- e. Provider's initial assessment of member's functional skills, limitations, and treatment needs
- f. Standardized assessments of baseline functioning and/or progress related to treatment
- g. Proposed schedule of treatment hours and school hours for members in school or being homeschooled
- h. Most recent Birth to 3 IFSP or school IEP
- i. Plan of care (unless fully summarized in Section VIII of this form)
- j. Discharge criteria and transition plan

31. For **subsequent** PA requests, attach and label all of the following documents, and include the member name and member ID on each document:

- a. Updated medical provider's prescription for behavioral treatment services (if prescription will expire before end of PA period)
- b. Updated medication list (if any)
- c. Updated psychological or neuropsychological diagnostic reports (if any)
- d. Updated standardized assessments of progress related to treatment (if any)
- e. Updated Birth to 3 IFSP or school IEP (if any)
- f. Proposed schedule of treatment hours and school hours for members in school or being homeschooled
- g. Summary of progress related to treatment goals (unless fully summarized in Section IX of this form)
- h. Updated POC (unless fully summarized in Section VIII of this form)
- i. Discharge criteria and transition plan

SECTION XII — SIGNATURE

I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this form. I, or someone with comparable qualifications, will be available to the other team member(s) at all times when he or she is in the home alone working with the child/family.

32. **SIGNATURE** — Licensed Professional

33. Credentials

34. Date Signed

35. Name — Licensed Professional (Print)

ATTACHMENT 7

Searching for an Online Handbook Topic

Providers use the following steps to search for a topic in the ForwardHealth Online Handbook:

1. Go to the ForwardHealth Portal at www.forwardhealth.wi.gov/.
2. Select Online Handbooks from the Providers box on the left side of the page.
3. Click Advanced Search in the Select from the following options area to display the Advanced Search panel.
4. Enter a topic number (or any other key word) into the text box and click Search. All records matching the search criteria will be displayed on the left side of the screen.
5. Click show links to display the hyperlink to the topic.

Note: If multiple hyperlinks display after clicking show links, click any link to retrieve the topic information. All of the links on the list refer to the same topic as found in the various service areas of the Online Handbook.

ATTACHMENT 8

1500 Health Insurance Claim Form Completion Instructions for Behavioral Treatment Services

These instructions are for the completion of the 1500 Health Insurance Claim Form for ForwardHealth. Refer to the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the National Uniform Claim Committee (NUCC) and available on their website, to view instructions for all item numbers not listed below.

Use the following claim form completion instructions, in conjunction with the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC, to avoid denial or inaccurate claim payment. Be advised that every code used is required to be a valid code, even if it is entered in a non-required field. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations to covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans) must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial insurance billing as determined by ForwardHealth. When submitting paper claims, if the member has any other commercial health insurance, providers are required to complete and submit an Explanation of Medical Benefits form, F-01234, along with the completed paper claim.

Submit completed paper claims and the completed Explanation of Medical Benefits form, as applicable, to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Item Number 6 — Patient Relationship to Insured

Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 9 — Other Insured's Name (not required)

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 9a — Other Insured's Policy or Group Number (not required)

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 9d — Insurance Plan Name or Program Name (not required)

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 10d — Claim Codes (Designated by NUCC)

When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available on the NUCC website under Code Sets.

Item Number 11 — Insured's Policy Group or FECA Number (not required)

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

Item Number 11d — Is There Another Health Benefit Plan?

This field is not used for processing by ForwardHealth.

Item Number 19 — Additional Claim Information (Designated by NUCC)

When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

If a provider bills an unlisted (or not otherwise classified) procedure code, a description of the procedure must be indicated in this field. If a more specific code is not available, the provider is required to submit the appropriate documentation, which could include a PA request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

Item Number 22 — Resubmission Code and/or Original Reference Number

This field is not used for processing by ForwardHealth.

Section 24

The six service lines in section 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Item Number 24C — EMG

Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

Item Number 29 — Amount Paid (not required)

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits form for each other payer as an attachment(s) to their completed paper claim.

ATTACHMENT 9

Place of Service Codes for the Behavioral Treatment Benefit

The table below includes allowable place of service (POS) codes for the behavioral treatment benefit. Behavioral assessment and treatment may occur in either in the home, community, or clinic. Based on standard Wisconsin Medicaid definitions of POS codes that constitute “home” and “clinic,” the following codes are allowed.

Place of Service Codes and Descriptions	
Code	Description
03	School
04	Homeless shelter
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
13	Assisted living facility
14	Group home
16	Temporary lodging
49	Independent clinic
50	Federally qualified health center
71	Public health clinic
72	Rural health clinic

Note: When behavioral treatment services are provided in community settings, such as parks, public libraries, or stores, providers should list POS code 12 (home) on the claim.

ATTACHMENT 10

Maximum Allowable Fees for Behavioral Treatment Services

The following table includes the maximum allowable fees for each procedure code covered under the ForwardHealth behavioral treatment benefit. Behavioral treatment licensed supervisors and focused treatment licensed supervisors are billing providers for the behavioral treatment benefit and submit claims to ForwardHealth for behavioral treatment services.

Procedure Code	Procedure Code Description	Treatment Model	Renderer	Rate
0359T	Behavior identification assessment , by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	Comprehensive or focused	Licensed supervisor	\$198.90*
0360T	Observational behavioral follow-up assessment , includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	Comprehensive or focused	Licensed supervisor or treatment therapist	\$36.67
0361T	Observational behavioral follow-up assessment , includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	Comprehensive or focused	Licensed supervisor or treatment therapist	\$36.67
0364T	Adaptive behavior treatment by protocol , administered by technician, face-to-face with one patient; first 30 minutes of technician time	Comprehensive	Licensed supervisor or treatment therapist or treatment technician	\$14.32
		Focused	Licensed supervisor	\$66.30
			Treatment therapist	\$33.34

Procedure Code	Procedure Code Description	Treatment Model	Renderer	Rate
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	Comprehensive	Licensed supervisor or treatment therapist or treatment technician	\$14.32
		Focused	Licensed supervisor	\$66.30
			Treatment therapist	\$33.34
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	Comprehensive	Licensed supervisor or treatment therapist or treatment technician	\$14.32
		Focused	Licensed supervisor	\$66.30
			Treatment therapist	\$33.34
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	Comprehensive	Licensed supervisor or treatment therapist or treatment technician	\$14.32
		Focused	Licensed supervisor	\$66.30
			Treatment therapist	\$33.34
0368T	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time.	Comprehensive or focused	Licensed supervisor or treatment therapist	\$36.67
0369T	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	Comprehensive or focused	Licensed supervisor or treatment therapist	\$36.67
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	Comprehensive or focused	Licensed supervisor or treatment therapist	\$89.67*

* Behavior Identification Assessment and Family Adaptive Behavior Treatment Guidance are not timed. A single unit of this procedure code represents all time necessary to complete the assessment or guidance.