FORWARDHEALTH

PRIOR AUTHORIZATION / CARE PLAN ATTACHMENT (PA/CPA) COMPLETION INSTRUCTIONS

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

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (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 services.

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

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

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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

SECTION I — MEMBER INFORMATION

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

Element 2 — Telephone Number — Member
Enter the telephone number, including the area code, of the member. If the member's telephone number is not available, enter "N/A."

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

Element 4 — Start of Care Date
Enter the date that covered services began for the member in MM/DD/CCYY format. The start of care date is the date of the member's first billable home care visit. This date remains the same until the member is discharged.

Element 5 — Certification Period
Enter the beginning and ending dates of the certification period respectively in the "From" and "To" portions of this element in MM/DD/CCYY format. The certification period identifies the period of time the attending physician orders services to be provided.

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

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

Example

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

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

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

Element 6 — Principal Diagnosis
Enter the appropriate and most-specific principal diagnosis information. Include the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code, diagnosis code description most relevant to the service requested, and the date of onset in MM/DD/CCYY format. If the member's condition is chronic or long-term in nature, use the date of exacerbation. The ICD diagnosis code must correspond with the ICD description.

Element 7 — Surgical Procedure and Other Pertinent Diagnoses
Enter the surgical procedure information, if any, that is relevant to the care rendered or the services requested. Include the appropriate ICD diagnosis code, diagnosis code description, and the date of the surgical procedure in MM/DD/CCYY format. The month and year of the date of the surgical procedure must be included. Use "00" if the exact day of the month is unknown.

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

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

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

Element 8 — Durable Medical Equipment
Identify the item(s) of durable medical equipment (DME) ordered by the attending physician and currently used by the member. Enter "N/A" if no known DME has been ordered.

Element 9 — Functional Limitations
Enter an "X" next to all items that describe the member's current limitations as assessed by the attending physician and the nurse or therapist. If "Other" is checked, specify the other functional limitations in the space provided.

Element 10 — Activities Permitted
Enter an "X" next to all activities that the attending physician permits and/or that are documented in the attending physician's orders. If "Other" is checked, specify the other activities the member is permitted in the space provided.

Element 11 — Medications
Enter the attending physician's orders for all of the member's medications, including the dosage, frequency, and route of administration for each. If any of the member's medications cause severe side effects or reactions that necessitate the presence of a nurse, therapist, home health aide, or personal care worker, indicate the details of these circumstances in this element.

Element 12 — Allergies
List any medications or other substances to which the member is allergic (e.g., adhesive tape, iodine, specific types of food). If the member has no known allergies, indicate "no known allergies."

Element 13 — Nutritional Requirements
Enter the attending physician's instructions for the member's diet. Include specific dietary requirements, restrictions, fluid needs, tube feedings, and total enteral nutrition.

Element 14 — Mental Status
Enter an "X" next to the term(s) that most accurately describes the member's mental status. If "Other" is checked, provide further explanation in the space provided.

Element 15 — Prognosis
Enter an "X" next to the one term that specifies the most appropriate prognosis of the member.

SECTION IV — ORDERS

Element 16 — Orders for Services and Treatments
Indicate the following as appropriate for each individual service:

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

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

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

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

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

Element 17 — Goals / Rehabilitation Potential / Discharge Plans
Enter the attending physician's description of the following:

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

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

Element 18 — Date Physician Last Saw Member
Enter the date the attending physician last saw the member in MM/DD/CCYY format. If this date cannot be determined during the home visit, enter "Unknown."

Element 19 — Dates of Last Inpatient Stay Within 12 Months
Enter the admission and discharge dates of the member's last inpatient stay within the previous 12 months, if known. Enter "N/A" if this element does not apply to the member.

Element 20 — Type of Facility for Last Inpatient Stay
Enter one of the following single-letter responses to identify the type of facility of the member's last inpatient stay, if applicable:

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

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

Element 21 — Current Information
For initial certification periods, enter the clinical findings of the initial assessment visit for each involved discipline. Describe the clinical facts about the member that require PDN, personal care (PC), home health, and PCC services and include specific dates in MM/DD/CCYY format.

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

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

Element 22 — Home or Social Environment
Enter information that will justify the need for PDN, PC, and home health services and enhance the ForwardHealth consultant's understanding of the member's home situation (e.g., member lives with mentally disabled son who is unable to provide care or assistance to member). Include the availability of caretakers (e.g., parent's work schedule). The description may document problems that are, or will be, an impediment to the effectiveness of the member's treatment or rate of recovery.

Element 23 — Medical and/or Nonmedical Reasons Member Regularly Leaves Home
Enter the reasons that the member usually leaves home. Indicate both medical and nonmedical reasons, including frequency of occurrence of the trips (e.g., doctor appointment twice a month, barbershop once a month, school every weekday for three hours).

Element 24 — Names of Other Providers with Whom This Case Is Shared
This element is required for all providers who case share with other providers providing PDN, PC, and home health services. Enter the names of other providers with whom this cased is shared.

SECTION VI — SIGNATURES

Provider-created formats must contain the following statement that is included on the PA/CPA: "Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws."

Elements 25 and 26 — Signature and Date Signed — Authorized Registered Nurse (RN) Completing Form
The registered nurse (RN) completing the POC is required to sign and date the POC. Providers not using the PA/CPA for the POC must add the following statement to their provider-created POC. The following statement must be accompanied by the authorized RN's dated signature: "As the nurse completing this plan of care (POC), I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form."

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

Element 27 — Date of Verbal Orders for Initial Certification Period
Enter the date the nurse signing in Element 24 received verbal orders from the attending physician to start care for the initial certification period. If the nurse did not receive verbal orders, leave this element blank.

Element 28 — Date Physician-Signed Form Received
Enter the date the provider received the signed and dated POC from the attending physician.

Element 29 — Name and Address — Attending Physician
Enter the attending physician's name and complete address. The street, city, state, and ZIP+4 code must be included. The attending physician is the physician who ordered the medically necessary services.

Elements 30 and 31 — Signature and Date Signed — Attending Physician
The attending physician is required to sign and date the POC for medically necessary services within 20 working days following the initial start of care. For subsequent periods of recertification, the attending physician is required to sign and date the POC for medically necessary services prior to the provision of services.

Provider-created formats must contain the following statement accompanying the attending physician's dated signature: "The member is under my care, and I have ordered the services on this POC."

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

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

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

Elements 32 and 33 — Countersignature and Date Signed
When two or more providers share a PDN case, it is necessary to designate only one RN who receives orders from the attending physician to complete Element 24. **All** providers sharing the case are required to obtain a copy of the POC for the effective certification period and **countersign** and **date** Elements 31 and 32 to document that the provider has reviewed the POC and will execute it as written. Dated countersignatures required for Elements 31 and 32 must be completed before providing PDN services.

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

Provider-created formats must contain the following statement accompanying the authorized nurse's dated countersignature: "As the provider countersigning this POC, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form."