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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00787 (02/2019) | **STATE OF WISCONSIN** |
| **FORWARDHEALTH****prior authorization requirements exemption request for Computed Tomography (CT), Magnetic Resonance (MR), and magnetic resonance elastography (MRE) Imaging Services** |
| ForwardHealth requires certain information to enable BadgerCare Plus and Wisconsin Medicaid to authorize and pay for medical services provided to eligible members.Personally identifiable information about providers or other entities is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for services. This form is mandatory; use the fillable version or an exact paper copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. When completed, email the completed fillable form to dhspaexemption@wisconsin.govor mail a paper copy of the form to the following address:Physician Policy Analyst Department of Health ServicesDivision of Medicaid ServicesP.O. Box 309Madison, WI 53701-0309Providers, provider groups, or health systems with questions regarding the requirements in Section II may email them to dhspaexemption@wisconsin.gov.A provider or health system may complete this form to demonstrate implementation of a decision support tool that is used by its providers who order computed tomography (CT), magnetic resonance (MR), or magnetic resonance elastography (MRE) imaging services. Upon approval, ForwardHealth will recognize the decision support tool as an appropriate alternative to current fee-for-service prior authorization (PA) requirements for CT, MR, and MRE imaging services. Providers or health systems that use the tool will not be required to obtain PA for CT, MR, and MRE imaging services for Medicaid and BadgerCare Plus fee-for-service members. ForwardHealth recognizes decision support tools do not make any medical or diagnostic decisions or medical necessity determinations, otherwise act upon patient data in any professional capacity, or determine the type of processes a provider or health system needs to make such determinations or decisions. While decision support tools provide information that may assist in diagnostic decisions or determinations, medical judgment and care decisions remain the responsibility of the health system and its providers. ForwardHealth recognizes that decision support tools are regularly enhanced to incorporate new research and that decision support may currently be unavailable or insufficient for certain services. ForwardHealth may review the policies and requirements outlined herein, with appropriate provider input, in response to the continued development of decision support. ForwardHealth may discontinue this agreement after initial approval if ForwardHealth determines the provider or health system either no longer meets the approval requirements outlined herein or does not demonstrate meaningful use of decision support to minimize inappropriate utilization.**INSTRUCTIONS:** Print or type clearly. Identify the requesting health system and contact information for an individual able to provide additional detail or clarification.  |
| SECTION I – PROVIDER INFORMATION |
| 1. Name – Provider, Provider Group, or Health System       |
| 2. National Provider Identifier (NPI) – Provider, Provider Group, or Health System      |
| 3. Name – Contact Person      | 4. Title – Contact Person      |
| 5. Phone Number – Contact Person      | 6. Email Address – Contact Person      |
| SECTION II – REQUIREMENTS |
| The provider, provider group, or health system must meet the following requirements for approval of their decision support tool as an appropriate alternative to current Wisconsin Department of Health Services’ PA requirements:7. The provider or health system has fully implemented a decision support tool for use among its providers to order CT, MR, and MRE imaging services.a. Identify the decision support tool in use.      b. Identify the date on which the decision support tool was fully implemented and functional.      8. The provider or health system has developed a quality improvement plan to address over- and under-utilization by providers. The guidelines include interventions, timelines, and outcome measures. **Detailed quality improvement plans should be submitted with this application.** The outcome measures should include, at a minimum:a. Aggregate score for all providers, measuring consistency with system recommendations based on the reporting standards described in more detail in Section III.b. Subset scores, grouped by primary and specialty care.c. Aggregate outcome measures identified in the quality improvement plan.9. The health system agrees to report outcome measures to ForwardHealth for each full six-month interval (January 1 through June 30 and July 1 through December 31) by July 31 and January 31 of each year. 10. The health system agrees to identify and submit to ForwardHealth the names and NPIs of individual providers who will use the decision support tool to order CT, MR, and MRE imaging services. 11. The health system agrees to submit to ForwardHealth additions, deletions, and other updates as needed to the provider exemption list to ensure current and accurate information. Large lists should be provided along with semi-annual outcome measure reporting. |
| SECTION III – SUPPORTING INFORMATION Provide the following information in the space below each statement or as a separate attachment. |
| 12. Describe the provider educational component(s) of the decision support tool, including any real-time access to radiologists when requested by the ordering provider and/or feedback to providers who vary significantly from the recommendations of the decision support tool.      |
| 13. Describe the internal processes to provide feedback to individual providers as needed regarding their use of and compliance with the decision support tool.      |
| 14. Describe the calculation of the aggregate score for consistency with system recommendations to be submitted to ForwardHealth, including the basic components of the score and qualifications to the score’s calculation, such as the exclusion of certain types of orders.      |
| SECTION IV – ATTESTATION |
| By signing below, the health system attests to satisfying all requirements defined in this form. |
| 15. Name – Authorized Agent (Print)      | 16. Title – Authorized Agent      |
| 17. **SIGNATURE** – Authorized Agent | 18. Date Signed |