Division of Medicaid Services F-00787 (02/2019)

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.gov or mail a paper copy of the form to the following address:

Physician Policy Analyst Department of Health Services Division of Medicaid Services P.O. Box 309 Madison, WI 53701-0309

Providers, 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

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3. Name – Contact Person	4. Title – Contact Person	
5. Phone Number – Contact Person 6. Email Add	dress – Contact Person	
SECTION II – REQUIREMENTS		
The provider, provider group, or health system must me tool as an appropriate alternative to current Wisconsin I	eet the following requirements for approval of their decision support Department of Health Services' PA requirements:	
 The provider or health system has fully implemente MR, and MRE imaging services. 	d a decision support tool for use among its providers to order CT,	
a. Identify the decision support tool in use.		
b. Identify the date on which the decision support tool was fully implemented and functional.		
providers. The guidelines include interventions, time plans should be submitted with this application	ty care.	
9. The health system agrees to report outcome measurthrough June 30 and July 1 through December 31)	ures to ForwardHealth for each full six-month interval (January 1 by July 31 and January 31 of each year.	
 The health system agrees to identify and submit to will use the decision support tool to order CT, MR, a 	ForwardHealth the names and NPIs of individual providers who and MRE imaging services.	
	alth additions, deletions, and other updates as needed to the ate information. Large lists should be provided along with semi-	
SECTION III – SUPPORTING INFORMATION Provide the following information in the space below ea	ch statement or as a separate attachment.	
	the decision support tool, including any real-time access to er and/or feedback to providers who vary significantly from the	
Describe the internal processes to provide feedback compliance with the decision support tool.	k to individual providers as needed regarding their use of and	

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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.	
17. SIGNATURE – Authorized Agent	18. Date Signed