DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01629 (12/2019)

STATE OF WISCONSIN
Wis. Admin. Code §§ DHS 101.03(96m), 106.02(9), 107.02(3)

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) 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 ID 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 PA requests, provide an updated diagnosis if available.)

5. Was diagnostic information submitted with a prior PA?

- ❑ Yes. Provide 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 8.

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)

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

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

- ❑ Yes. Provide the PA number ______________________
- ❑ No. Continue to Element 9.

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

❑ Yes. Continue to Element 10. Provide updated details. (Do not repeat previously reported information.)

❑ No. Skip Element 10 and go to Section V, Element 11.

10. 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			

SECTION V – AGE-NORMED TESTING

11. Were all test results submitted with a prior PA?

- ❑ Yes. Enter the PA number ____________________. Continue to Element 12.
- ❑ No. Details of recent testing (test date, clinician who completed testing, tool, and results) are included in attached documents. Continue to Element 12.
- ❑ No. Details of recent testing are documented in the tables below.

Document the most recent age-normed testing completed by the provider or other entities (such as a diagnostician or school).

Assessment Type	Test Date	Clinician	Tool	Results / Score
IQ				
Cognition (Other)				
Communication				
Adaptive Behavior				
Other				
Other				

Skill Assessment

Date of Most Recent Assessment	Curriculum Tool(s) (Criterion-Referenced Tool)	Frequency of Reassessments

12. Functional behavior assessment (FBA) and/or functional analysis (FA) is required for any behaviors targeted for reduction, such as aggression, destructive behavior, self-injury, behaviors that put the member or others at risk of injury, or stereotypy. The plan of care (POC) must include behavior reduction **and** functional replacement goals related to each problem behavior. Has FBA or FA been completed to develop the POC?

- ❑ No. Continue to Element 13.
- ❑ Yes. Details of recent FBA or FA (date, tool used, behaviors, and behavior functions) are included in attached documents. Continue to Element 13.
- ❑ Yes. Details of FBA or FA are included in the table below.

Date of FBA or FA	Tool	Maladaptive Behavior(s) and Identified Function of Each Behavior

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

13. Enter the frequency of the 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 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		

SECTION VII – POC

14. Attach a current POC that addresses all of the following:
    - Start date of treatment with the agency
    - Treatment approach or protocol to be used
    - Details of any medical conditions that may impact delivery of treatment or the member's response to treatment, such as visual or hearing impairment, genetic differences, seizures, digestion or elimination problems, sleep disorder, nutrition concerns, or mental health concerns
    - Specific, objective, functional goals for the member, to be met by the end of the authorization period, with measurable criteria for assessing progress and mastery
    - Behavior reduction **and** functional replacement goals for each behavior targeted for reduction
    - Plan for family involvement, including frequency and modes
    - Specific, measurable goals (if family treatment guidance is requested)
    - Details about interpretation services or other accommodations for communication barriers when needed
    - Discharge criteria and transition plan

    ❑ The current POC is included in the attached documentation.

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

15. Attach a summary of recent progress that addresses all of the following:
    - A description of the member's response to treatment during the most recent authorization, including signs of overall improved functioning
    - The introductory date and progress or mastery date for each targeted goal
    - Measurable baselines and progress measures toward member and family goals, using consistent units of measurement that compare functioning at the beginning and end of the authorization period
    - In the case of limited progress, identification of barriers to progress and corrective actions that have been attempted, including FBA, FA, or consultation with other specialties
    - In cases of limited progress, a corrective action plan to address the identified barriers, with a rationale for ongoing treatment at the level of service requested

    ❑ The current progress summary is included in the attached documentation.

SECTION IX – CARE COLLABORATION

16. Check the boxes next to all services the member is currently receiving or is expected to begin receiving during the requested authorization period.

- ❑ Community-Based Occupational Therapy or Physical Therapy
- ❑ Community-Based Speech Therapy
- ❑ Community-Based Mental Health Services
- ❑ Personal Care / Home Health Services
- ❑ Comprehensive Community Services
- ❑ School District Special Education or Therapies
- ❑ Birth to 3
- ❑ Children's Long-Term Support Waiver Services
- ❑ Other: ___________________________________

For each service checked above, indicate the services currently provided and the frequency of intervention. Provide detail about the mode and frequency of care collaboration with each entity.

Note: All services provided on a weekly basis must be included on the member's weekly schedule.

Details of current services (services provided, frequency, and mode and frequency of care collaboration) are included:

- ❑ In attached documentation.
- ❑ In the table below.

Service Type	Services Provided	Frequency	Care Collaboration Mode and Frequency

SECTION X – ATTACH SUPPORTING DOCUMENTATION

Refer to the grid below for required supporting documentation based on the member's age and the type of PA request. All documents must include the member's name and ID on the first page.

Note: Additional information may be requested with any PA request to establish the medical necessity of the service.

Supporting Documentation	Comprehensive Treatment for Members Under Age 6		Focused Treatment for Members Under Age 6 / All Treatment for Members Age 6 and Older	
Check box if included with submission.	**Initial**	**Amendments and Subsequent**	**Initial**	**Amendments and Subsequent**
❑ PA/BTA	Not required	Not required	Required	Subsequent only (not required with amendments)
❑ Valid Prescription for All Dates of Service	Required	Update if Needed	Required	Update if Needed
❑ Diagnostic Report	Report or Attestation of Diagnosis	Updates Only	Report for Comprehensive; Attestation for Focused	Updates Only
❑ Provider's Initial Assessment Report	Optional (Must Retain on File)	Not Required	Required	Not Required
❑ Age-Normed Test Results	Not Required	Not Required	Required for Comprehensive	Updates Only
❑ POC	Required	Required	Required	Required
❑ Schedule of Treatment, School, and Services	Not required	Not required	Required	Required
❑ Progress Summary	N/A	Required Annually	N/A	Required
❑ Results of Curriculum-Based Assessment	Not Required	Required	Required	Required
❑ Individualized Education Program	Not Required	Not Required	Required	Updates Only

SECTION XI – 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 they are in the home alone working with the child/family.

17. **SIGNATURE** – Licensed Professional

18. Credentials

19. Name – Licensed Professional (Print)	20. Date Signed