FORWARDHEALTH

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

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

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

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. 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. 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 these instructions and the instructions on the form to determine which sections to complete. Where noted in these instructions and on the form, the provider may attach material from the member's records.

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 to obtain the correct spelling of the member's name. If the name or the spelling of the name on the ForwardHealth ID card and the Enrollment Verification System do not match, use the spelling from the Enrollment Verification System.

Element 2: Date of Birth – Member
Enter the member's date of birth in mm/dd/ccyy format.

Element 3: Member ID 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 (for example, commercial insurance) or by a different provider (for example, the member has received behavioral treatment elsewhere), but this is the requesting provider's first request to Wisconsin 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 EVALUATIONS

Complete this section for all initial PA requests. For subsequent PA requests, provide an updated diagnosis if available.

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, go 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 reevaluated, skip the remainder of Section III and go to Element 8 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 current diagnosis for which the member is 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 or needs that may indicate a need for diagnostic reevaluation. Providers are expected to verify that the member's diagnosis continues to be accurate. Refer to the ForwardHealth Online Handbook on the Portal for guidelines on diagnostic standards.

SECTION IV – PREVIOUS TREATMENT

Complete this section for all initial PA requests. For subsequent PA requests, provide updates as needed.

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, physical therapy, daily living skills training, and psychotherapy. Other treatment that is currently in progress should be documented in Section IX of the PA/BTA.

Element 8

If details of the member's previous treatment were submitted with a prior PA, include the prior PA number. If not, continue to Element 9.

Element 9

If the member has **completed** any type of treatment since the prior PA, continue to Element 10 and include updated details. Do not repeat information in this element that was that was reported on the prior PA.

If the member has not completed any treatment since the prior PA, skip the remainder of Section IV and go to Element 11 in Section V.

Element 10

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 (for example, "see Initial Assessment").

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

SECTION V – AGE-NORMED TESTING

Element 11

Document the most recent age-normed testing and skill assessments that have been conducted. If the test results were submitted with a prior PA, enter the prior PA number and continue to Element 12. If test results were not submitted with a prior PA, providers should submit all recent age-normed test results and skill assessments with this PA request.

Element 12

Functional behavior assessment and/or functional analysis 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. Indicate whether or not functional behavior assessment or functional analysis has been completed to develop the POC. Providers should submit test results with this PA request.

SECTION VI – TREATMENT TEAM

Complete this section for all initial and subsequent PA requests.

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 13

In the Direct Service Hours column, enter the number of direct service hours recommended in the member's 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—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 (for example, 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.

SECTION VII – POC

Element 14
Check the box to confirm that a current POC is included in the attached documentation. The POC must address 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

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

Element 15
Check the box to confirm that a current progress summary is included in the attached documentation. The progress summary should address 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 functional behavior assessment, functional analysis, 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

SECTION IX – CARE COLLABORATION

Element 16
Check the boxes next to all the services that the member is currently receiving or is expected to begin receiving during the requested authorization period. For each service checked, indicate the services currently provided and the frequency of intervention. Provide detail about the mode and frequency of care collaboration with each entity. Indicate whether these details are included in attached documentation or in the table provided on the form.

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

SECTION X – ATTACH SUPPORTING DOCUMENTATION
Refer to the grid 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. For members under age 6 who are receiving **comprehensive** treatment, submit the documentation requested in the left column. For members under age 6 who are receiving **focused** treatment, or for members age 6 and older who are receiving either focused treatment **or** comprehensive treatment, submit the documentation requested in the right column.

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

SECTION XI – SIGNATURE

Element 17: 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 18: Credentials
Enter the credentials of the person who signed in Element 17 (for example, Ph.D.).

Element 19: Name – Licensed Professional (Print)
Include the printed name of the Medicaid-enrolled behavioral treatment provider, who must be a licensed professional.

Element 20: Date Signed
Enter the date the PA/BTA was signed by the licensed professional in mm/dd/ccyy format.