FORWARDHEALTH

PRIOR AUTHORIZATION / RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT ATTACHMENT (PA/RSUD) 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 from ForwardHealth for residential substance use disorder (SUD) 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 residential substance use treatment at a particular frequency to meet particular outcomes. 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/Residential Substance Use Disorder Treatment Attachment (PA/RSUD) form, F-02567. The **bold** headings directly reflect the name of the element on the PA/RSUD form.

Attach the completed PA/RSUD form 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/RSUD form is designed to be used for all residential SUD treatment PA requests. Where noted on the form and in these instructions, 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 (EVS) 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 EVS do not match, use the spelling from the EVS.

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's ID number. Do not enter any other numbers or letters.

SECTION II – SERVICE REQUEST

Element 4
Check the appropriate box to indicate the level of care being requested.

Residential SUD treatment services must be clinically and medically necessary and provided in a facility with 24-hour supervision certified by the Division of Quality Assurance as either a DHS 75.54 Medically Monitored Residential Treatment Service facility or a DHS 75.53 Transitional Residential Treatment Service facility. The checked box must reflect the level of care requested for the member.

Element 5
Check the appropriate box(es) to indicate any additional complexities that are present. Check all that apply. For intellectual/developmental disability, this must be a diagnosed condition that poses potential barriers to treatment participation or effectiveness. Documentation of the member's diagnosed disability must be provided with the supporting clinical documents.

SECTION III – DIAGNOSTIC EVALUATION

Element 6
Indicate up to three substances used by the member that have been evaluated using diagnostic criteria. If the member uses or meets diagnostic criteria for fewer than three substances, only the substances that pertain to the requested residential treatment must be reported. If the member uses more than three substances, provide information on the three substances most relevant to treatment.

Element 7
For each substance identified in Element 6, check all diagnostic criteria that apply to the member in the corresponding column. These criteria correspond to the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) diagnostic criteria for SUD.

Element 8
Indicate up to two secondary psychiatric or mental health diagnoses.

SECTION IV – AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) CRITERIA

Element 9
Provide a brief relevant history and current information for each ASAM dimension. Include the most pertinent information that substantiates the requested level of service. This information may be included in separate documentation or by filling in the table in Element 9.

Element 10
Document the member's risk rating and level of care rating for each ASAM dimension according to the treatment criteria described in The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Check only one box per dimension to indicate the member's current risk level and only one box per dimension to indicate the member's level of care rating for each ASAM dimension. Each ASAM dimension may have a unique level of care and risk rating.

Element 11
Document the member's overall level of care rating as indicated by the complete ASAM assessment, according to the treatment criteria described in The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Select only one overall rating.

SECTION V – TREATMENT READINESS
Note: Providers are advised that responses in this section are not intended to exclude members from residential treatment. Responses may sometimes result in requests for additional documentation to substantiate the medical necessity of the request.

Element 12
Check the appropriate box to indicate whether or not the member is currently detoxified from drugs or alcohol (that is, **not** in active physiological withdrawal).

Element 13
Check the appropriate box to indicate whether or not the member is seeking treatment on a voluntary, rather than involuntary, basis. For example, if the member is seeking treatment exclusively in response to a requirement placed by a court, family member, or other entity, this constitutes an involuntary basis for treatment and "No" should be checked.

Element 14
Check the appropriate box to indicate whether or not the member has attempted any type of professionally supervised SUD treatment in the past. This may include one or more different treatment options and can include either outpatient or inpatient treatment. Efforts to address substance use concerns via peer-based interventions, such as 12-step programs, are not considered professionally supervised treatment.

SECTION VI – SIGNATURE

Element 15: SIGNATURE – Licensed Professional
The signature of the Wisconsin Medicaid-enrolled licensed professional who evaluated and referred the member for residential SUD treatment is required.

Element 16: Division of Safety and Professional Services (DSPS) Credentials
Enter the Division of Safety and Professional Services (DSPS) credentials of the licensed professional who signed the PA/RSUD form in Element 15.

Element 17: Date Signed
Enter the month, day, and year the PA/RSUD form was signed in mm/dd/ccyy format.

Element 18: Name – Licensed Professional (Print)
Include the printed name of the person who signed the PA/RSUD form in Element 15.

Element 19: SIGNATURE – Clinical Supervisor
The signature of the clinical supervisor of the Wisconsin Medicaid-enrolled licensed professional is only required if the licensed professional in Element 15 is in training (IT). (For example, their license has an "-IT" extension.)

Element 20: DSPS Credentials
Enter the DSPS credentials of the clinical supervisor who signed the PA/RSUD form in Element 19.

Element 21: Date Signed
Enter the month, day, and year the PA/RSUD form was signed in mm/dd/ccyy format.

Element 22: Name – Clinical Supervisor (Print)
Include the printed name of the person who signed the PA/RSUD form in Element 19.