

FORWARDHEALTH PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA) COMPLETION INSTRUCTIONS

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

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

Under Wis. Stats. § 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 services.

The use of this form is mandatory when requesting PA for certain items. If necessary, 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 determination about the request.

INSTRUCTIONS

Dispensing providers are required to complete the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), F-11054, and request PA using the ForwardHealth Portal or on paper. Prescribers and dispensing providers are required to retain a completed copy of the form.

Providers may submit PA requests on a PA/ENPA in one of the following ways:

- 1) For requests submitted on the ForwardHealth Portal, providers may access www.forwardhealth.wi.gov/.
- 2) For paper PA requests by fax, dispensing providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the PA/ENPA to ForwardHealth at 608-221-8616.
- 3) For paper PA requests by mail, dispensing providers should submit a PA/RF and the PA/ENPA to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

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 spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters.

Element 3 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 4 — Gender — Member

Check the appropriate gender of the member.

SECTION II — PRESCRIBER INFORMATION

Element 5 — Name — Prescriber

Enter the prescriber's first and last name.

Element 6 — National Provider Identifier — Prescriber

Enter the 10-Digit National Provider Identifier of the prescriber.

Element 7 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 8 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

SECTION III — PRESCRIPTION OR ORDER INFORMATION

A copy of the prescription or order that is not greater than one year old must be submitted with each PA request.

Element 9

Indicate the product trade name(s) and calories per day of the enteral nutrition product(s) prescribed or ordered.

Element 10

Indicate the date the prescription or order was written. Prescriptions or orders should not be greater than one year old.

SECTION IV — DIETARY ASSESSMENT AND PLAN

Element 11

Indicate the member's total daily caloric requirements. Total daily caloric requirements are the calculated caloric needs from all nutritional sources.

Element 12

Indicate whether or not the enteral nutrition product(s) prescribed or ordered in Element 9 provides 100 percent of the member's total daily caloric requirements indicated in Element 11. If the enteral nutrition product(s) requested does not meet 100 percent of the member's total daily caloric needs, check the most appropriate reason.

Element 13

Indicate how the enteral nutrition product(s) prescribed or ordered in Element 9 will be administered. If the enteral nutrition product will be administered using both mouth and feeding tube, indicate the calories per day administered orally and the calories per day administered via feeding tube.

SECTION V — CLINICAL INFORMATION

Element 14 — Primary Diagnosis Code and Description as It Relates to Enteral Nutrition

Enter the appropriate and most-specific primary *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the enteral nutrition product(s) requested. The ICD diagnosis code must correspond with the ICD description.

Element 15 — Secondary Diagnosis Code and Description as It Relates to Enteral Nutrition

Enter the appropriate and most-specific secondary ICD diagnosis code and description most relevant to the enteral nutrition product(s) requested. The ICD diagnosis code must correspond with the ICD description. A secondary diagnosis is not required.

Element 16 — Anthropometric Measures

Indicate the anthropometric measures of the member. Anthropometric measures are the member's current height in inches, the date measured, the member's current weight in pounds, and the date measured.

Element 17

Indicate the member's medical condition by checking all that apply.

Element 18

For the member's medical condition checked in Element 17, indicate the specific details of the medical condition, including treatment recommendations, as it relates to enteral nutrition in the space provided. If applicable, indicate any clinical changes that have occurred since previously approved PAs have been submitted.

Element 19

For enteral nutrition products administered orally, describe why a diet of regular- or altered-consistency table foods and beverages is not nutritionally sufficient for the member and why nutritional requirements can be met using only enteral nutrition products.

Element 20

For specially formulated enteral nutrition products (procedure codes B4149, B4153, B4154, B4161, and B4162), describe why general purpose enteral nutrition products do not meet the member's nutritional needs, are not tolerated, or are not clinically appropriate for the member.

SECTION VI — ADDITIONAL INFORMATION

Element 21

Indicate any additional information in the space provided, including a description of the member's dietary assessment and dietary plan. Attach additional pages if space is needed.

SECTION VII — PRIOR AUTHORIZATION REQUEST INFORMATION FOR CALORIES PER DAY

Information in this section should correspond with information indicated on the PA/RF.

Element 22 — Procedure Code

Indicate the Healthcare Common Procedure Coding System (HCPCS) procedure code of the enteral nutrition product(s) requested.

Element 23 — Modifiers, if Applicable

Indicate the modifiers, if applicable.

Element 24 — Product Trade Name

Indicate the trade name of the product requested.

Element 25 — Calories Per Day Requested

Indicate the calories per day requested.

Element 26 — Number of Days Requested

Indicate the number of days requested.

Element 27 — Units Requested

Indicate the units requested (Elements 25 x Element 26 / 100). If the unit calculation does not result in a whole number, the units requested should be rounded up to the nearest whole number.

SECTION VIII — PRIOR AUTHORIZATION REQUEST INFORMATION FOR MILLILITERS PER DAY

This section should be completed for PA requests for HCPCS procedure codes B4102 and B4103 only. Information in this section should correspond with information indicated on the PA/RF.

Element 28 — Procedure Code

Indicate the HCPCS procedure code of the enteral nutrition product(s) requested.

Element 29 — Modifiers, if Applicable

Indicate the modifiers, if applicable.

Element 30 — Product Trade Name

Indicate the trade name of the product requested.

Element 31 — Milliliters Per Day Requested

Indicate the milliliters per day requested.

Element 32 — Number of Days Requested

Indicate the number of days requested.

Element 33 — Units Requested

Indicate the units requested (Elements 31 x Element 32 / 500). If the unit calculation does not result in a whole number, the units requested should be rounded up to the nearest whole number.

SECTION IX — AUTHORIZED SIGNATURE OF BILLING PROVIDER

Element 34 — Signature

The billing provider or authorized representative acting on behalf of the billing provider is required to complete and sign this form.

Element 35 — Printed Name

Print the name of the authorized representative who signed Element 34.

Element 36 — Position Title

Indicate the position title of the authorized representative who signed Element 34.

Element 37 — Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

FOR OFFICE USE ONLY

Leave this section blank.