FORWARDHEALTH
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA) 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 service. The use of this form is mandatory when requesting PA for certain items.

INSTRUCTIONS
Under Wis. Admin. Code § DHS 106.02(9)(e), the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested oxygen-related equipment or supplies. All oxygen-related services must be prescribed by a physician prior to providing the service. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Providers may attach a photocopy of the physician's prescription to the completed Prior Authorization/Oxygen Attachment (PA/OA), F-11066, or the prescribing physician may sign and date the PA/OA in lieu of attaching the prescription. The prescription (or PA/OA) must be signed and dated within 30 days prior to receipt by ForwardHealth. Attach the PA/OA to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers are required to attach a completed Record of Actual Daily Oxygen Use form, F-11067, or a copy of the member's oxygen use records to the PA/OA for members who reside in a nursing home.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests to ForwardHealth by fax at (608) 221-8616 or by mail 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 — PROVIDER INFORMATION

Element 1 — Name — Medical Equipment Vendor
Enter the name of the medical equipment vendor (oxygen provider).

Element 2 — Medical Equipment Vendor's National Provider Identifier (NPI)
Enter the NPI of the medical equipment vendor (oxygen provider). The NPI in this element must correspond with the provider name listed in Element 1.

Element 3 — Telephone Number — Medical Equipment Vendor
Enter the medical equipment vendor's telephone number, including area code.

Element 4 — Requested Start Date
Enter the requested grant date for this PA request in MM/DD/CCYY format.

Element 5 — Name — Person Completing Form
Enter the name of the person completing this form if other than the treating physician.

Element 6 —Title — Person Completing Form
Enter the title of the person completing this form if other than the treating physician (e.g., respiratory therapist, home health nurse, billing manager).

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 8 — Prescribing Physician's NPI
Enter the NPI of the prescribing physician. The NPI in this element must correspond with the provider name listed in Element 7.

Element 9 — Address — Prescribing Physician
Enter the complete address (street, city, state, and ZIP+4 code) of the prescribing physician.

Element 10 — Telephone Number — Prescribing Physician
Enter the prescribing physician's telephone number, including area code.

SECTION II — MEMBER INFORMATION

Element 11 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the 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 identification card and the EVS do not match, use the spelling from the EVS.

Element 12 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 13 — Height and Weight — Member
Enter the member's height in inches and weight in pounds. This field is optional unless height and weight are related to respiratory diagnosis.

Element 14 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 15 — Place of Service
Select the appropriate place of service (POS) code. If POS code "31" (Skilled nursing facility) or "32" (nursing facility) are selected, complete Element 16.

Element 16 — Name and Address — Facility (if applicable)
Enter the name and address of the nursing facility in which the member resides, if applicable.

SECTION III — CLINICAL INFORMATION

Element 17 — Estimated Length of Need
Enter the estimated time (in months) that the member will require oxygen. If the physician expects that the member will require the item for the duration of his or her life, then enter "99."

Element 18 — Diagnosis — Codes and Descriptions
Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis codes and descriptions most relevant to the oxygen-related services requested. The ICD diagnosis code must correspond with the ICD description.

Note: Medical equipment vendors may choose to provide only a written description.

Element 19 — Qualifying Test
Enter the results of the qualifying test taken within 60 days prior to the date of submission or requested start date of the PA request. The criteria for coverage of oxygen-related services include one or both of the following:

- Oxygen saturation level (SAO_2) of 88 percent or lower.
- Arterial blood gas level (PO_2) of 55 mm/Hg or lower.

Test results must have been taken within 60 days prior to the date of submission or the requested start date. Test results are to be available in the member's record or case file.

Element 20
Enter the oxygen liter flow rate/number of hours per day prescribed by a physician. If not used on a scheduled basis, describe circumstances and frequency of use.

Element 21 — Type of Oxygen Prescribed
Indicate the type of oxygen requested.

Element 22 — Means of Delivery Prescribed
Indicate the means of delivery of the oxygen.

Element 23
Answer questions a-c about portable oxygen and member mobility information.

Element 24
If the member's arterial blood gas level (PO_2) is 56 mm/Hg or above or the member's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

Element 25
Describe the medical condition of the member that supports the use of oxygen (e.g., describe why the member needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

Element 26 — Date of Prescription
Enter the date of the physician's prescription in MM/DD/CCYY format.

Element 27 — Prescription as Written
Enter the physician's prescription as it is written. If the prescribing physician signs the PA/OA, ForwardHealth will accept it in lieu of the physician's written prescription, and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of receipt by ForwardHealth or the requested start date of the PA request.

Element 28 — SIGNATURE — Prescribing Physician
The original signature of the provider prescribing the oxygen-related services must appear in this element, or the physician's prescription must be attached to the PA request.

Element 29 — Date Signed
Enter the month, day, and year the PA/OA was signed in MM/DD/CCYY format.