FORWARDHEALTH
PRIOR AUTHORIZATION / ENTERAL NUTRITION FORMULA ATTACHMENT (PA/ENFA) 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 services.

The use of this form is mandatory when requesting PA for certain items. 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 Formula Attachment (PA/ENFA), 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/ENFA in one of the following ways:
- For requests submitted on the Portal, providers may access www.forwardhealth.wi.gov/.
- For PA requests by fax, dispensing providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the PA/ENFA to ForwardHealth at 608-221-8616.
- For PA requests by mail, dispensing providers should submit a PA/RF and the PA/ENFA 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 ID card and the EVS do not match, use the spelling from the EVS.

Element 2: Member ID 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.

SECTION II – PRESCRIBER INFORMATION

Element 4: Name – Prescriber
Enter the prescriber's first and last name.

Element 5: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescriber.

Element 6: Phone Number – Prescriber
Enter the phone number, including area code, of the prescriber.

Element 7: National Provider Identifier – Prescriber
Enter the National Provider Identifier of the prescriber.

SECTION III – PRESCRIPTION OR ORDER INFORMATION
A copy of the prescription or order not greater than one year old must be submitted with each PA request.

Element 8
Indicate the date the prescription or order was written. Prescriptions or orders should not be greater than one year old.

Element 9
Indicate the total amount of enteral nutrition formula(s) and/or food thickener(s) prescribed or ordered.

SECTION IV – DIETARY ASSESSMENT AND PLAN

Element 10
Indicate the member's total daily caloric requirements. Total daily caloric requirements are the calculated caloric needs from all nutritional sources.

SECTION V – CLINICAL INFORMATION

Element 11: 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 formula(s) requested. The ICD diagnosis code must correspond with the ICD description.

Element 12: 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 formula(s) requested. The ICD diagnosis code must correspond with the ICD description. A secondary diagnosis is not required.

Element 13: Height and Weight Measurements
Indicate the member's current height in inches, the date measured, the member's current weight in pounds, and the date measured.

Element 14
Indicate the member's medical condition by checking all the conditions that apply.

Element 15
For the member's medical condition checked in Element 14, regardless of the member's age, indicate in the space provided the specific details of the medical condition, including treatment recommendations, as it relates to enteral nutrition. If applicable, indicate any clinical changes that have occurred since previously approved PAs have been submitted.

Element 16
For enteral nutrition formula, regardless of the member's age, describe why a diet of regular- or altered-consistency table foods and beverages is not nutritionally sufficient for the member and why nutritional requirements necessitate the use of enteral nutrition formula.

Element 17
For specially formulated enteral nutrition formula, regardless of the member's age, describe why general purpose enteral nutrition formula does not meet the member's nutritional needs, is not tolerated, or is not clinically appropriate for the member.

Element 18
For food thickeners, regardless of the member's age, describe why a diet of regular-consistency table foods and beverages is not tolerated and how the member's health care team recommends the use of food thickeners (scoops, packets, or tablespoons per day and consistency level).

Element 19
For diagnoses of failure to thrive or malnutrition, regardless of the member's age, describe the member's anthropometric measurements (for example, height-for-length, progression along a growth chart, percentiles, or body mass index). Include any lab values or other clinical information to substantiate the member's nutritional deficiency.

SECTION VI – ADDITIONAL INFORMATION

Element 20
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 – PA REQUEST INFORMATION FOR CALORIES PER DAY
Information in this section should correspond with information indicated on the PA/RF.

Element 21: Procedure Code
Indicate the Healthcare Common Procedure Coding System (HCPCS) procedure code of the enteral nutrition formula(s) requested.

Element 22: Modifiers
Indicate the modifiers.

Element 23: Calories Per Day Requested
Indicate the calories per day requested.

Element 24: Number of Days Requested
Indicate the number of days requested.

Element 25: Units Requested
Indicate the units requested (Element 23 x Element 24 / 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 – PA REQUEST INFORMATION FOR MILLILITERS PER DAY
This section should be completed for PA requests for procedure codes where units are defined as milliliters only. Information in this section should correspond with information indicated on the PA/RF.

Element 26: Procedure Code
Indicate the HCPCS procedure code of the enteral nutrition formula(s) requested.

Element 27: Modifiers
Indicate the modifiers.

Element 28: Milliliters Per Day Requested
Indicate the milliliters per day requested.

Element 29: Number of Days Requested
Indicate the number of days requested.

Element 30: Units Requested
Indicate the units requested (Element 28 x Element 29 / 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 – PA REQUEST INFORMATION FOR OUNCES PER MONTH

This section should be completed for PA requests for procedure codes where units are defined as ounces only. Information in this section should correspond with information indicated on the PA/RF.

Element 31: Procedure Code

Indicate the HCPCS procedure code of the food thickener(s) requested.

Element 32: Modifiers

Indicate the modifiers.

Element 33: Ounces Per Month Requested

Indicate the ounces per month requested.

Element 34: Number of Months Requested

Indicate the number of months requested.

Element 35: Units Requested

Indicate the units requested (Element 34 x Element 35). If the unit calculation does not result in a whole number, the units requested should be rounded up to the nearest whole number.

SECTION X – AUTHORIZED SIGNATURE OF BILLING PROVIDER

Element 36 – Signature

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

Element 37 – Printed Name

Print the name of the authorized representative who signed Element 36.

Element 38 – Position Title

Indicate the position title of the authorized representative who signed Element 36.

Element 39 – Date Signed

Enter the month, day, and year the form was signed in mm/dd/ccyy format.

FOR FORWARDHEALTH USE ONLY

Leave this section blank.