FORWARDHEALTH

PRIOR AUTHORIZATION / INTENSIVE OUTPATIENT PROGRAM ATTACHMENT (PA/IOP) 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 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 intensive outpatient program (IOP) 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" 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/Intensive Outpatient Program Attachment (PA/IOP) form, F-03325. The **bold** headings directly reflect the name of the element on the PA/IOP form.

Attach the completed PA/IOP 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 www.forwardhealth.wi.gov/, by fax to 608-221-8616, or by mail to:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

INSTRUCTIONS

The PA/IOP form is designed to be used for all intensive outpatient 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 type of service being requested. Select only one. If Substance Use Disorder (SUD) Only is selected, complete Section III. If Mental Health Only is selected, complete Section IV. If Co-Occurring SUD and Mental Health is selected, complete both Sections III and IV.

Element 5
Check the appropriate box(es) to indicate any additional complexities that are present. Check all that apply.

SECTION III – ASSESSMENT FOR SUBSTANCE USE TREATMENT

This section should be completed if either SUD Only or Co-Occurring SUD and Mental Health are selected in Element 4. This section is optional if Mental Health Only is selected in Element 4.

Element 6: Date – Most Recent American Society of Addiction Medicine (ASAM) Assessment
Enter the date of the most recent ASAM assessment.

Element 7: Name – Clinical Assessor
Enter the name of the clinician that completed the ASAM assessment.

Element 8: Division of Safety and Professional Services (DSPS) Credentials – Clinical Assessor
Enter the clinician's DSPS credentials.

Element 9: Name – Clinical Supervisor
The name of the clinical supervisor of the Wisconsin Medicaid-enrolled clinical assessor is only required if the clinical assessor in Element 8 is in training (IT). (For example, their license has an "-IT" extension.)

Element 10: DSPS Credentials – Clinical Supervisor
Enter the clinical supervisor's DSPS credentials. This field is only required if the clinical assessor is in training.

Element 11: Diagnosed Substance Use Conditions
Indicate a maximum of three of the member's diagnosed substance use conditions. Include both the name of the diagnosis and the diagnosis code. Nicotine Use Disorder cannot be the primary and only diagnosis.

Element 12: Determined ASAM Level of Care
Check the appropriate box to indicate the member's determined ASAM level of care.

Element 13
Check the appropriate box to indicate whether the substance use treatment plan was completed.

Element 14: Member's Medication-Assisted Treatment (MAT) Status
Check the appropriate box to indicate the member's MAT status. If the selection that the member has refused MAT at this time is checked, indicate the date of refusal and make note of the refusal in the member's record. If MAT is not recommended for the member's diagnosis, indicate the SUD diagnosis. This selection will be clinically reviewed. If MAT is not offered or made available at the facility, the PA will be denied.

SECTION IV – ASSESSMENT FOR MENTAL HEALTH TREATMENT
This section should be completed if either Mental Health Only or Co-Occurring SUD and Mental Health are selected in Element 4. This section is optional if SUD Only is selected in Element 4.

Element 15: Date – Most Recent Mental Health Assessment
Enter the date of the member's most recent mental health assessment.

Element 16: Name – Clinical Assessor
Enter the name of the clinician who completed the assessment.

Element 17: DSPS Credentials – Clinical Assessor
Enter the clinical assessor's DSPS credentials.

Element 18: Name – Supervisor
The name of the clinical supervisor of the Wisconsin Medicaid-enrolled clinical assessor is only required if the clinical assessor in Element 17 is in training (IT). (For example, their license has an "-IT" extension.)

Element 19: DSPS Credentials – Supervisor
Enter the clinical supervisor's DSPS credentials. This field is only required if the clinical assessor is in training.

Element 20: Diagnosed Mental Health Conditions
Indicate a maximum of three of the member's diagnosed mental health conditions. Include both the name of the diagnosis and the diagnosis code.

Element 21: Assessment Tool Used
Check the appropriate box for the tool used for the member's mental health assessment and provide the score, as applicable.

Element 22
Check the appropriate box to indicate whether the mental health treatment plan was completed.

Element 23: Level of Care Indicated by the Assessment
Enter the member's level of care that was indicated by the mental health assessment.

SECTION V – TREATMENT CURRICULUM
This section should be completed for all service requests.

Element 24
If a standardized program is planned, check the appropriate box to indicate the type of treatment provided.

SECTION VI – SIGNATURE

Element 25: SIGNATURE
The signature of the person who completed the PA request and is attesting to its accuracy is required.

Element 26: Date Signed
Enter the month, day, and year the PA/IOP form was signed in mm/dd/ccyy format.