FORWARDHEALTH

PRIOR AUTHORIZATION / SPEECH-GENERATING DEVICE PURCHASE RECOMMENDATION ATTACHMENT 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 only 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.

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 equipment or supplies. If the space provided is not sufficient, attach additional pages for the provider's responses and/or an occupational therapy (OT) or physical therapy (PT) report if available. All speech-generating devices (SGDs) must be prescribed by a physician. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

The speech-language pathologist is required to complete the Prior Authorization/Speech-Generating Device Skills and Needs Profile Attachment form, F02494, and the Prior Authorization/Speech-Generating Device Purchase Recommendation Attachment form, or to submit a speech and language pathology (SLP) report documenting the same content as the two attachments. The speech-language pathologist is required to submit the completed forms or documentation to the SGD vendor with any additional required documentation attachments. The SGD vendor may submit the forms and any required documentation by fax to ForwardHealth at 608-221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste. 88
313 Blettner Blvd.
Madison, WI 53784

SECTION I – MEMBER INFORMATION

Element 1: Name – Member
Enter the member's last name, followed by their 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: 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 – SERVICE INFORMATION

Element 4: Medical Diagnosis
Enter the member's medical diagnosis.

Element 5: Treatment Diagnosis
Enter the member's treatment diagnosis.

Element 6
Check the appropriate box to indicate whether or not the member has received SGD treatment following completion of the skills and needs profile. If yes, list the start date, the end date, and the frequency of the treatment sessions.

Element 7
Check the appropriate box to indicate whether or not the member has participated in an SGD trial. If yes, list the start date and end date of the trial.

SECTION III – DOCUMENTATION OF SGDS CONSIDERED BUT RULED OUT

Element 8
Describe any SGD options considered but ruled out during the skills and needs profile assessment, treatment sessions, or the trial period. If relevant, highlight why other SGD options were eliminated from further consideration for the member, including less costly alternatives.

SECTION IV – RECOMMENDED SGD AND DESCRIPTION OF FEATURE MATCH

Element 9
List the name and manufacturer of the SGD hardware. Describe feature match (for example, portability, durability, battery life, size of display).

Element 10
List the SGD software. Describe feature match (for example, symbols, navigation, and display features such as static or dynamic display, visual scene, grid, list, symbol size, spacing, and number on display).

Element 11: Language System / Organization / Page Set
Select all options that apply, and describe feature match to the selected options.

Element 12: Access Method, Settings, and Accessories
Select all options that apply, and describe switches, switch placement, and type of scanning. If "Other" is checked, describe feature match with recommended access methods, settings, and accessories. Attach OT or PT reports if relevant.

Element 13
List adaptations, accessories, or mounts if relevant. Describe feature match to the identified options. Attach OT or PT reports if relevant.

SECTION V – SUMMARY OF PROGRESS DOCUMENTED AS A RESULT OF TREATMENT OR TRIAL PERIOD
Complete this section if "Yes" is checked for either Element 6 or Element 7.

Element 14

Provide details necessary to document how the member's ability to communicate improved with the use of the SGD. Include documentation of the SGD trial period here. Documentation should target:

- How the member communicated at the start of treatment with the SGD. Examples of documentation may include, but are not limited to: baselines of established goals, frequency and types of cues, activity selection, or activity structure for targeted SGD use.
- How the member currently communicates with the device. Examples of documentation may include, but are not limited to: measureable change from baseline performance, changes in frequency and types of cues, changes in activity selection or activity structure, examples of generated messages, interactions with caregivers/family members or school staff and care providers, or other situations relevant to the treatment implemented.

SECTION VI – SGD PURCHASE RECOMMENDATION WITHOUT THE NEED FOR SGD TREATMENT OR A TRIAL PERIOD

Complete this section if "No" was checked for both Elements 6 and 7.

Note: Complete this section once the SGD and accessories (if relevant) have been matched to the skills and needs of the member and the member has demonstrated relevant skills using the SGD.

Element 15

Provide documentation of relevant skills for the member to use the SGD. Documentation should target:

- Relevant skills, including language skills (for example, vocabulary, syntax), social skills (for example, communicative functions), and operational skills (on/off, navigation).
- Relevant context requirements (for example, frequency or types of cues), including examples of messages produced as part of completion of the skills and needs profile. If relevant, include rationale for not requiring SGD treatment or a trial period to confirm recommendation (for example, degenerative diagnosis, history of using an SGD).

SECTION VII – SUPPORT FOR RECOMMENDED SGD AND DOCUMENTATION OF TREATMENT NEEDS

Element 16

Document evidence that the family and/or team members are able to provide essential supports relevant to the SGD matched to the member's skills and needs, including specific examples of use in the home, school, and community with cue levels if applicable.

Element 17: Recommendations for SLP Treatment Following Placement of Recommended SGD

Select all that apply. Either provide rationale for why the member does not require treatment following placement of the SGD, or provide or attach a treatment plan if treatment following placement of the SGD is recommended. If the member receives Birth to 3 services or school-based services, attach the Individual Education Plan (IEP) or Individual Family Services Plan (IFSP).

SECTION VIII – AUTHORIZED SIGNATURE

Element 18: SIGNATURE AND CREDENTIALS – Speech-Language Pathologist

Enter the signature and credentials of the speech-language pathologist.

Element 19: Date Signed

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