FORWARDHEALTH

PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA) 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 to receive PA for certain services. 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.

Attach the completed Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA), F-11036, to the Prior Authorization Request Form (PA/RF), F-11018, the member's assessment and recovery/treatment plan, a physician prescription, and the Child and Adolescent Needs and Strengths assessment summary, the Child and Adolescent Functional Assessment Scale, or the Achenbach Child Behavior Checklist and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at 608-221-8616, via the ForwardHealth Portal by accessing www.forwardhealth.wi.gov/, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

INSTRUCTIONS

The information contained in the PA/ITA is used to make a decision about the amount and type of psychotherapy that is approved for Medicaid or BadgerCare Plus reimbursement. Thoroughly complete each section and include information that supports the medical necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form. **Indicate on the PA/ITA the intended use of the attached materials.**

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 – Date of Birth – Member

Enter the date of birth of the member (in mm/dd/ccyy format).

Element 3 – Member ID Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

SECTION II – PROVIDER INFORMATION

Element 4: Name – Rendering Provider
Enter the name of the Medicaid-certified psychotherapist/substance abuse counselor who is leading the in-home treatment team.

Element 5: Rendering Provider's National Provider Identifier
Enter the National Provider Identifier (NPI) of the Medicaid-certified psychotherapist/substance abuse counselor identified in Element 4.

Element 6 – Phone Number – Rendering Provider
Enter the phone number, including the area code, of the Medicaid-certified psychotherapist/substance abuse counselor identified in Element 4.

Element 7 – Credentials – Rendering Provider
Enter the credentials of the Medicaid-certified psychotherapist/substance abuse counselor (for example, Ph.D.).

SECTION III – SERVICE REQUEST

Element 8
Check the appropriate box on the form to indicate the authorization for which the PA is being requested:
- Initial authorization
- Second authorization
- Third authorization
- Fourth authorization

Element 9
Enter the requested start and end dates for this authorization period. The initial authorization may be backdated up to 10 working days prior to the receipt of the request at ForwardHealth if the provider requests backdating in writing and documents the clinical need for beginning services immediately.

Element 10
Indicate the name and qualifications of the second team member. Attach a résumé, if available. If the second provider is a Medicaid-certified psychotherapy/substance abuse provider, indicate their qualifications by entering their rendering provider NPI.

Element 11
Enter the pattern and frequency of treatment planned over this PA grant period. If the primary psychotherapist is involved in treatment more than 50 percent of the time (that is, if the primary therapist's direct treatment hours exceed those of the second team member's), special justification should be noted on the request.

Element 12
Indicate the travel time required to provide the service. Travel time should consist of the time to travel from the provider's office to the member's home or from the previous appointment to the member's home.

SECTION IV – SEVERELY EMOTIONALLY DISTURBED CRITERIA

Element 13
Complete the checklist to determine whether or not the individual meets the criteria for severe emotional disturbance (SED):
a. List the primary diagnosis and diagnosis code in the space provided.
b. Complete the checklist to determine whether or not the individual would substantially meet the criteria for SED.
c. Check those boxes that apply. The individual must have one symptom or two functional impairments described as follows.

Symptoms

Psychotic symptoms – Serious mental illness (for example, schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.

Suicidality – The individual must have made one attempt within the last three months or have significant ideation about or have made a plan for suicide within the past month.

Violence – The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

Functional Impairments (Compared to Expected Developmental Level)

Functioning in self care – Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

Functioning in the community – Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, and judgment, and a value system that results in involvement or potential involvement in the juvenile justice system.

Functioning in social relationships – Impairment in social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

Functioning in the family – Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (for example, fire setting, serious and chronic destructiveness), inability to conform to reasonable limitations, and expectations that may result in removal from the family or its equivalent.

Functioning at school/work – Impairment in school or work is manifested in any one of the following:

- The inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence towards others
- Meeting the definition of "children with disabilities" under Wis. Admin. Code ch. PI 11 and Wis. Stat. § 115.76
- The inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with supervisor and other workers, or hostile behavior on the job

d. Check the boxes that apply to indicate which service systems the individual is receiving services from.

e. Check the boxes that apply to indicate the reason enrollment criteria may be waived. Enrollment criteria may be waived under the following circumstances:

- The member substantially meets the criteria for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning, but would likely do so without in-home mental health and substance abuse treatment services. Attach an explanation.
- The member substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

SECTION V – ATTACH SUPPORTING DOCUMENTATION

Element 14

The following materials must be attached and labeled:

a. Attach the PA/RF. The PA/RF may be obtained from ForwardHealth. Providers should use process type "126" in Element 2. "HealthCheck Other Services" should be marked in Element 1. Providers should use the appropriate procedure codes, modifiers, and descriptions in Elements 19, 20, and 22 of the PA/RF.

   The quantity requested in Element 23 of the PA/RF should represent the total hours for the grant period requested and Element 24 of the PA/RF should represent charges for all hours indicated in Element 23.

b. Attach the assessment and recovery/treatment plan. Providers may use their own assessment and treatment plan forms as long as all the elements and documentation requirements for strength-based assessment and recovery and treatment planning are included, or they may use the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment, F-00212, which includes the assessment, the multi-agency treatment plan, and the in-home recovery/treatment plan. Both a multi-agency treatment plan and an in-home treatment plan are required. These plans may be combined, making sure all required elements are included.

c. Attach a physician's prescription/order for in-home treatment services dated not more than one year prior to the requested first date of service.

d. Attach the Child and Adolescent Needs and Strengths assessment summary, the Child and Adolescent Functional Assessment Scale, or the Achenbach Child behavior checklist.

e. A substance abuse assessment must be included if substance abuse-related services are part of the member's treatment program. The assessment information may be provided separately or included in the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment.

SECTION VI – SIGNATURE
The PA/ITA must be signed and dated by the certified psychotherapy/substance abuse treatment provider who is leading the in-home treatment team. In signing, the individual accepts responsibility for supervising the other individuals who are part of the in-home treatment team. In signing, they provide assurance that an individual who meets the criteria for a Medicaid-certified psychotherapy/substance abuse treatment provider will be available to the other team members when they are in the home alone with the child/family.

Element 15: Signature – Certified Psychotherapist/Substance Abuse Counselor
Enter the signature of the Medicaid-certified psychotherapist/substance abuse counselor.

Element 16: Credentials
Enter the credentials of the Medicaid-certified psychotherapist/substance abuse counselor (for example, Ph.D.).

Element 17: Date Signed
Enter the month, day, and year the PA/ITA was signed (in mm/dd/ccyy format).