

## FORWARDHEALTH OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN 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 (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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 Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103, may be used by providers of mental health outpatient services to document their assessment of a member's clinical condition and treatment/recovery plan. This information provides the clinical information required to request prior authorization (PA) for services covered by ForwardHealth.

The use of this form is mandatory when requesting 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/Psychotherapy Attachment (PA/PSYA), F-11031, the member's assessment and treatment/recovery plan, and the physician prescription (if necessary) 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 by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### GENERAL INSTRUCTIONS

Complete Elements 1-7 when submitting the initial PA request and at least once every three years when the performing provider remains unchanged. For continuing PA on the same individual, it is not necessary to rewrite Elements 1-7; corrections/updates on information in Elements 1-7 should be made in Elements 8 through 10. When Elements 1-7 are not rewritten, submit a copy of what had previously been written, along with updated information in the remaining elements of the Outpatient Mental Health Assessment and Treatment/Recovery Plan. Medical consultants reviewing the PA requests have a file containing the previous requests, but they base their decisions on the clinical information submitted, so it is important to present all current, relevant clinical information.

### SECTION I — INITIAL ASSESSMENT / REASSESSMENT

Include the date of the initial assessment/reassessment (in MM/DD/CCYY format). Complete this section at least every three years.

#### Element 1 — Presenting Problem

Enter the consumer's presenting problem.

#### Element 2 — Diagnosis

Enter the date of the five-axis *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3) diagnosis.

**Element 3 — Symptoms**

Enter the symptoms presented by the consumer that were used to formulate the diagnoses given in Element 1. Assess the severity of the symptoms and indicate them as mild, moderate, or severe.

**Element 4 — Strength-Based Assessment**

Document the assessment of the consumer, basing it on the consumer's strengths. Include current as well as historical biopsychosocial data. Include mental status, developmental, school/vocational, cultural, social, spiritual, medical, past and current traumas, substance use/dependence and outcome of treatment, and past mental health treatments and outcomes. Include the consumer's view of the issues. For a child, give the parent/primary caregiver's view of the issues. The provider may attach an assessment dated within three months of the request.

**Element 5**

Indicate the family/community support for this consumer. Indicate other services the consumer is receiving or to which he or she has been referred.

**Element 6**

Present the strengths that could impact the consumer's progress on goals; address any barriers to the progress.

**Element 7**

Indicate whether or not there has been a consultation to clarify the diagnosis and/or treatment and, if so, the credentials of the consultant. Indicate the date of the most recent consultation (in MM/DD/CCYY format). Briefly describe the results of the consultation or attach a copy of the report, if available.

**SECTION II — SUBSEQUENT ASSESSMENTS**

Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews.

**Element 8**

Indicate any changes in Elements 1-7, including the current Global Assessment of Functioning, change in diagnoses (five axes), and supporting symptoms.

**Element 9**

Indicate the symptoms currently being exhibited by the consumer.

**SECTION III — TREATMENT / RECOVERY PLAN**

**Element 10**

Goals are general and answer the question, "What do the consumer and yourself, as therapist, want to accomplish in treatment?" Objectives are specific and answer the question, "What steps will the consumer and yourself, as therapist, be taking in therapy to help meet the stated goals?"

Indicate the goals of the consumer's treatment (short term for this PA period and long term for the next year).

For each objective, indicate the treatment modality (individual [I]; group [G]; family [F]; other [O] — specify) being implemented during this PA period. In the first column, indicate the behaviors you and the consumer have agreed upon as signs of improved functioning. In the second column, describe the progress, or lack thereof, in the behaviors identified in the first column since the last review. *Member report alone is not an observable sign.* In the third column, indicate changes in goals/objectives in the treatment/recovery plan.

**Element 11**

Indicate how the consumer's strengths are being utilized in meeting the goals of the treatment/recovery plan. If little or no progress is reported, discuss why you believe further treatment is needed for this consumer and how you plan to address the need for continued treatment. Discuss your plans for assisting the consumer in meeting his or her goals. If progress is reported, give rationale for continued services.

**Element 12**

Indicate whether the consumer is on any psychoactive medication and the date of the most recent medication check (in MM/DD/CCYY format). List psychoactive medications and target symptoms for each medication.

**SECTION IV — SIGNATURES**

**Element 13 — Signature — Rendering Provider**

**Element 14 — Date Signed**

**Element 15 — Signature — Consumer / Legal Guardian\***

**Element 16 — Date Signed**

- \* The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment (HFS 36.16[3], Wis. Admin. Code) will be met if this form is signed by the consumer or a legal guardian for children.