FORWARDHEALTH

PRIOR AUTHORIZATION INTENSIVE IN-HOME MENTAL HEALTH / SUBSTANCE ABUSE SERVICES ASSESSMENT AND RECOVERY / TREATMENT PLAN ATTACHMENT 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 (DHS 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 Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment, F-00212, may be used by providers of intensive mental health and substance abuse treatment services for children to document their assessment of a member's clinical condition and recovery/treatment plan. This information provides the clinical information required to request PA for services covered by ForwardHealth.

The use of this form is optional 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/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, HealthCheck screen documentation dated within 365 days prior to the grant date being requested, and Child and Adolescent Needs and Strength assessment summary, the Child and Adolescent Functional Assessment Scale, or the Achenbach Child Behavior Checklist, and send them 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

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 1-8 when submitting the initial PA request. For continuing PA on the same individual, it is not necessary to rewrite Elements 1-7; corrections/updates to information in Elements 1-8 should be made in Elements 8-10. When Elements 1-8 are not rewritten, submit a copy of what had previously been written, along with updated information in the remaining elements of the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment. 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 — 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 identification 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 Identification 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 — INITIAL PRIOR AUTHORIZATION REQUEST

Element 4 — Date of Initial Assessment / Reassessment

Enter the date of the initial assessment/reassessment.

Element 5 — Presenting Problem

Enter the member's presenting problem.

Element 6

Enter the five-axis *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or, for children up to age 4, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3) diagnoses.

Element 7 — Symptoms

Enter the symptoms presented by the member that were used to formulate the diagnoses given in Element 6. Assess the severity of the symptoms and indicate them as mild, moderate, or severe.

Element 8 — Strength-Based Assessment

Document the assessment of the member, basing it on the member's strengths. Include current as well as historical psychological, social, and physiological data. Include mental status, developmental, cognitive functioning, school, vocational, cultural, social, spiritual, medical, past and current traumas, substance use/dependence and outcome of treatment, and past mental health treatment and outcome. Include the member'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 9

Describe the member and caregiver's perspectives, using their own words.

Element 10

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

Element 11

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. Attach a copy of the report.

SECTION III — SUBSEQUENT PRIOR AUTHORIZATION REQUESTS

Not required when the Initial Assessment section is completed. This section must be completed for subsequent PA requests.

Element 12

Indicate any changes in Elements 1-8, including the current Global Assessment of Functioning, change in diagnoses (five axes), and supporting symptoms.

Element 13

Indicate the symptoms currently being exhibited by the member.

SECTION IV — IN-HOME RECOVERY / TREATMENT PLAN

Element 14

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

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

In the first column, indicate the behaviors the provider and member have agreed upon as signs of improved functioning. In the second column, describe the progress in the behaviors identified in the first column since the last review. *Member/caregiver/school report alone is not an observable sign.* In the third column, indicate changes in goals/objectives in the recovery/treatment plan.

Element 15

Indicate how the member's strengths are being utilized in meeting the goals of the recovery/treatment plan.

Element 16
Indicate the rationale for in-home treatment. For an initial PA request, elaborate on this choice where prior outpatient treatment is absent or limited. For a continuing PA request, if little or no progress is reported, discuss why the provider believes further intensive in-home treatment is needed and how the provider plans to address the need for continued treatment. What strategies will the provider, as therapist, use to assist the member in meeting his or her goals? If progress is reported, give rationale for continued intensive in-home treatment and why the provider believes other, less intense services will not meet the member's needs.

Element 17
Indicate the expected date for termination of in-home treatment. Describe anticipated service needs and detailed aftercare plans following completion of in-home treatment and transition plans.

Element 18
Indicate whether or not the member is on any psychoactive medication and the date of the most recent medication check. If yes, enter the name and credentials of the prescriber.

Element 19
If the answer to Element 18 is yes, list psychoactive medications and dosages. Indicate target symptoms for each medication. Indicate whether informed consent is current for all medications.

SECTION V — MULTI-AGENCY TREATMENT PLAN

Element 20
The multi-agency plan describes the other agencies' involvement with the child and family and how the services of the other agencies are coordinated with the in-home team. The multi-agency treatment plan must be developed by representatives from all systems identified on the severe emotional disturbance eligibility checklist and address the role of each system in the overall treatment and the major goals for each agency involved. Identify the individual coordinating the multi-agency planning.

SECTION VI — SIGNATURES

Element 21 — Signature — Certified Psychotherapist / Substance Abuse Counselor
Enter the signature of the Medicaid-certified psychotherapist/substance abuse counselor.

Element 22 — Credentials
Enter the credentials of the Medicaid-certified psychotherapist/substance abuse counselor (e.g., Ph.D.).

Element 23 — Date Signed
Enter the month, day, and year the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment was signed (in MM/DD/CCYY format) by the certified psychotherapist or substance abuse counselor.

Element 24 — Signature — Member / Legal Guardian
Enter the signature of the member or legal guardian.

Element 25 — Date Signed
Enter the month, day, and year the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment was signed (in MM/DD/CCYY format) by the member or legal guardian.