ForwardHealth
Wisconsin serving you

Update
February 2010

No. 2010-07

Affected Programs: BadgerCare Plus, Medicaid
To: Master's Level Psychotherapists, Outpatient Mental Health Clinics, Psychiatrists, HMOs and Other Managed Care Programs

Changes to HealthCheck "Other Services" Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children as a Result of DHS 35 and Changes to DHS 105 and 107

This *ForwardHealth Update* announces changes to DHS 105 and 107, Wis. Admin. Code, for HealthCheck "Other Services" intensive in-home mental health and substance abuse treatment services for children with the adoption of DHS 35, Wis. Admin. Code. Also, effective immediately, providers may submit the Child and Adolescent Needs and Strengths Assessment summary as supporting documentation for a prior authorization request.

Changes to Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children

The Department of Health Services recently adopted DHS 35, Wis. Admin. Code, to update its policies and procedures for mental health services.

With the adoption of DHS 35, Wis. Admin. Code, policy and coverage-related changes have been made to DHS 105 (provider certification) and DHS 107 (covered services), Wis. Admin. Code, which affect coverage and prior authorization (PA) of mental health services. These changes are effective for dates of service (DOS) on and after June 1, 2009.

Changes to HealthCheck "Other Services" intensive in-home mental health and substance abuse treatment services for children include the following:

- Strength-based assessments have been added to the existing conditions for coverage of services listed under DHS 107.13(2)(a), Wis. Admin. Code.
- Documentation must meet DHS 35, Wis. Admin. Code, requirements. Refer to Attachment 1 of this *ForwardHealth Update* for elements and documentation requirements for strength-based assessment and recovery/treatment planning.

As a result of DHS 35, Wis. Admin. Code, ForwardHealth has revised the Prior Authorization/In-Home Treatment Attachment, F-11036 (dated 10/08), originally published in the June 2008 *Update* (2008-52), titled "Changes to Prior Authorization for HealthCheck 'Other Services' In-Home Mental Health and Substance Abuse Treatment Services for Children." The name and format of the form has changed. The form has been reduced to two pages and is now known as the Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA), F-11036 (02/10). Refer to Attachments 2 and 3 for the revised form and completion instructions.

In addition, a new optional form has been created, titled Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment, F-00212 (02/10). Providers may submit the member's assessment and recovery/treatment plan information on the new form. The form includes the model multi-agency treatment plan and in-home recovery/treatment plan and replaces the Model Multi-Agency Treatment Plan form, F-11106 (10/08), and Model Plan: In-Home Mental Health/Substance Abuse Treatment Services form, F-11105 (10/08), published in *Update* 2008-52. Refer to Attachments 4 and 5 for the form and completion instructions.

Providers are encouraged to begin using the new Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment and the revised PA/ITA as soon as possible. Both versions of the revised forms will still be accepted on paper until June 1, 2010. The revised versions of the forms are now available on the Forms page of the ForwardHealth Portal. The revised PA/ITA and completion instructions and the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment and completion instructions are available for Portal-submitted PAs.

Providers are reminded that all intensive in-home mental health and substance abuse treatment services for children must have at least one Medicaid-certified provider. The certified psychotherapy provider or substance abuse counselor is required to obtain his or her own rendering provider National Provider Identifier so that the clinic can be reimbursed as the billing provider for intensive in-home mental health and substance abuse treatment services for children.

Other Changes

Other changes to DHS 105 and 107, Wis. Admin. Code, either make language consistent with DHS 35, Wis. Admin. Code, or incorporate already existing statewide variances. A future *Update* will be published with additional information regarding advanced practice nurse prescribers with a psychiatric specialty.

Child and Adolescent Needs and Strengths Assessment Summary Accepted as Supporting Documentation for Prior Authorization Requests

Providers may submit the Child and Adolescent Needs and Strengths (CANS) assessment summary, as an alternative to the Child and Adolescent Functional Assessment Scale (CAFAS) or the Achenbach Child Behavior Checklist, as supporting documentation for a PA request for intensive in-home mental health and substance abuse treatment services for children.

Providers are required to be trained to use the CANS assessment tool. For information on how to obtain the CANS assessment tool or training, providers should contact Provider Services at (800) 947-9627.

The revised PA/ITA and completion instructions include information about the CANS assessment tool.

Policy Reminders

Intensive in-home mental health and substance abuse services for children are covered when all policy requirements are met. Refer to the January 2007 *Update* (2007-10), titled "HealthCheck 'Other Services' In-Home Mental Health and Substance Abuse Treatment Services for Children," for specific policy requirements. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as intensive in-home mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.

Intensive in-home mental health and substance abuse treatment services for children are not covered under the BadgerCare Plus Benchmark Plan.

The following are policy reminders for intensive in-home mental health and substance abuse treatment services for children.

Supporting Documentation for Requesting Prior Authorization

To request PA for intensive in-home mental health and substance abuse services, providers will need to submit the following completed forms and required documentation to ForwardHealth:

- The Prior Authorization Request Form, F-11018 (10/08).
- The PA/ITA.
- Physician's prescription/order signed and dated not more than one year prior to the requested first DOS.
- Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested DOS. A screen print from the secure Provider area of the Portal indicating the date of the last HealthCheck screening can be used.
- Current assessment and treatment plans. Providers may use their own assessment and treatment plan forms as long as all elements listed in Attachment 1 are included, or they may use the Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment, 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.
- The CANS assessment summary, the Achenbach Child Behavior Checklist, or the CAFAS.

Assessment

Additional policy regarding the assessment includes the following:

- The assessment shall be sufficient to identify the member's need for intensive in-home services. A comprehensive assessment shall be valid, accurately reflect the member's current needs, strengths, and functioning as well as historical psychological, social, and physiological data, past treatment and outcome, and include necessary consultation to clarify the diagnosis and treatment.
- A substance abuse assessment must be included if substance abuse-related programming is part of the member's treatment program.
- Initial treatment goals may include assessment of the member and family in the home and these goals may be procedural (e.g., complete assessment, complete substance abuse assessment). Where an assessment is part of the initial intervention, be specific and detailed as to the components of the assessment (e.g., psychiatrist will complete psychiatric evaluation, substance abuse counselor will complete substance abuse assessment) and when the assessment will be completed. Where appropriate, identify any standardized assessment tools that will be utilized.

In-Home Recovery/Treatment Plan

Additional policy regarding the in-home recovery/treatment plan includes the following:

- The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The methods must allow for a clear determination that the services provided meet criteria for covered services.
- The plan should clearly identify which team members are providing the services being requested.
- Services provided in the school, or that are primarily social or recreational in nature are not reimbursable.

Multi-Agency Treatment Plan

Additional policy regarding the multi-agency treatment plan includes the following:

- The individual who is coordinating the multi-agency planning should be clearly identified.
- The multi-agency treatment plan must be developed by representatives from all systems identified on the severe emotional disturbance (SED) eligibility checklist.
- The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved.
- Where an agency was not involved in the planning, the provider is required to document the reason and what attempts were made to include them.
- The plan must address the role of each system in the overall treatment and the major goals for each agency involved.

Child and Adolescent Needs and Strengths Assessment Summary, Achenbach Child Behavior Checklist, and the Child and Adolescent Functional Assessment Scale

Providers are required to complete and attach the results of the CANS assessment summary, Achenbach Child Behavior Checklist, or the CAFAS.

Information about these screening instruments is available on the Internet by searching for "Child and Adolescent Needs and Strengths assessment summary," "Achenbach Behavior Checklist," or "Child and Adolescent Functional Assessment Scale."

Travel Time

Travel time should consist of the time to travel round-trip between the provider's office or the previous/next appointment and the member's home, whichever is less. Travel time exceeding one hour one-way will generally not be authorized.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Elements and Documentation Requirements for Strength-Based Assessment and Recovery and Treatment Planning

Strength-Based Assessment

The assessment shall be sufficient to identify the member's need for mental health services. A comprehensive assessment shall be valid, accurately reflect the member's current needs, strengths and functioning, and be completed before beginning treatment under the treatment plan.

The assessment shall include the following:

- The member's presenting problem.
- Diagnosis established from the current *Diagnostic and Statistical Manual of Mental Disorders* including all five axes or, for children up to age four, the current *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.*
- The member's symptoms that support the given diagnosis.
- The member's strengths, and current and past psychological, social, and physiological data; information related to school or vocational, medical, and cognitive function; past and present trauma; and substance abuse.
- The member's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle, areas of functional impairment, and family and community support.
- Barriers and strengths to the member's progress and independent functioning.
- Necessary consultation to clarify the diagnosis and treatment.
- Treatments and services concurrently received by the member through other providers if the member is determined to have one or more co-occurring disorders. If substance abuse services are being provided by the same agency, a copy of the most current approved placement criteria summary.

Documentation

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. An assessment dated within three months of the request may be attached.

Recovery/Treatment Plan

The recovery and treatment plan shall be based upon the diagnosis and symptoms of the member and include:

- A mental health diagnosis and medications for mental health issues used by the member.
- The member's strengths and how they will be used to develop the methods and expected measurable outcomes that will be accomplished.

- The method to reduce or eliminate the symptoms causing the member's problems or inability to function in day-to-day living.
- The method to increase the member's ability to function as independently as possible.
- For a child or adolescent, a consideration of the child's or adolescent's development needs as well as the demands of the illness.
- The schedules, frequency, and nature of services recommended to support the achievement of the member's recovery goals, irrespective of the availability of services and funding.

Clinical review of the treatment plan shall address all of the following:
- The degree to which the goals of treatment have been met.
- Any significant changes suggested or required in the treatment plan.
- Whether any additional assessment or evaluation is recommended as a result of information received or observations made during the course of treatment.
- The member's assessment of functional improvement toward meeting treatment goals and suggestions for modification.

Documentation

The goals of treatment and specific objectives to meet those goals shall be documented in the member's recovery and treatment plan that is based on the strength-based assessment. In the recovery and treatment plan, the signs of improved functioning that will be used to measure progress toward specific objectives at identified intervals, agreed upon by the provider and member, shall be documented. A mental health diagnosis and medications for mental health issues used by the member shall be documented in the recovery and treatment plan.

ATTACHMENT 2
Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) Completion Instructions

(A copy of the "Prior Authorization/Intensive In-Home Treatment Attachment [PA/ITA] Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA) 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 use of this form is mandatory to receive PA for certain services. If necessary, 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 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
6406 Bridge Rd
Madison WI 53784-0088

GENERAL 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 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 — 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 — Telephone Number — Rendering Provider
Enter the telephone 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 (e.g., Ph.D.).

SECTION III — SERVICE REQUEST

Element 8
Indicate whether the PA request is for the:
- 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. Note the guidelines for the length of authorizations under the "General Instructions" section of these instructions.

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 his or her qualifications by entering his or her 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 (e.g., 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 for determination that an 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 an 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 (e.g., 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 community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and a value system that results in potential involvement or involvement in the juvenile justice system.
- Functioning in social relationships — Impairment of 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 (e.g., 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 any one of the following:
  a. Impairment in functioning at school is manifested by 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.
  b. Meeting the definition of "child with a disability" under ch. PI 11, Wis. Admin. Code, and s. 115.76, Wis. Stats.
  c. Impairment at work is 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. The individual is receiving services from one or more of the following service systems in addition to the Mental Health Service System:
     - Juvenile justice.
     - Social services.
     - Special education.
     - Child protective services.

Enrollment criteria are 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. 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 18, 19, and 21 of the PA/RF.

   The quantity requested in Element 22 of the PA/RF should represent the total hours for the grant period requested and Element 23 of the PA/RF should represent charges for all hours indicated in Element 22.

b. 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. The request must include documentation that the member had a comprehensive HealthCheck screening within 365 days prior to the grant date being requested. This documentation must be one of the following:
   - A screen print from the Provider area of the Portal indicating the date of the last HealthCheck screening.
   - A copy of the HealthCheck provider's billing form showing a claim for a comprehensive HealthCheck screening.
   - A copy of the HealthCheck provider's Remittance Advice showing a claim for a comprehensive HealthCheck screening.
   - A HealthCheck referral from the HealthCheck provider.
   - A letter on the HealthCheck provider's letterhead indicating the date on which they performed a comprehensive HealthCheck screening of the member.

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

f. 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, he or she provides 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 credential of the Medicaid-certified psychotherapist/substance abuse counselor (e.g., Ph.D.).

Element 17 — Date Signed
Enter the month, day, and year the PA/ITA was signed (in MM/DD/CCYY format).

ATTACHMENT 3
Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) (for photocopying)

(A copy of the "Prior Authorization/Intensive In-Home Treatment Attachment [PA/ITA]" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11036 (02/10)

STATE OF WISCONSIN
DHS 107.22(4), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) Completion Instructions, F-11036A. Providers may submit prior authorization (PA) requests to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member	3. Member Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Rendering Provider	5. Rendering Provider's National Provider Identifier
6. Telephone Number — Rendering Provider	7. Credentials — Rendering Provider

SECTION III — SERVICE REQUEST

8. **CHECK ONE** ❑ **Initial Authorization** ❑ **Second Authorization** ❑ **Third Authorization** ❑ **Fourth Authorization**

9. Enter the requested start and end dates for this authorization request. If backdating is needed for the initial PA request, it must be requested in writing, and the clinical rationale for starting services before authorization is obtained must be documented.

10. Enter the name and credentials of the second team member. Include his or her degree and the number of hours of supervised clinical work he or she has done with severe emotional disturbance (SED) children in the space provided (attach résumé, if available).

11. Enter the pattern and frequency of treatment planned over this PA grant period.

Certified Psychotherapist/Substance Abuse Counselor — ALONE

Individual Sessions: _____ hours per session; _____ sessions per week.

Family Sessions: _____ hours per session; _____ sessions per week.

Certified Psychotherapist / Substance Abuse Counselor and Second Team Member — TOGETHER

Individual Sessions: _____ hours per session; _____ sessions per week.

Family Sessions: _____ hours per session; _____ sessions per week.

Second Team Member — ALONE

Individual Sessions: _____ hours per session; _____ sessions per week.

Family Sessions: _____ hours per session; _____ sessions per week.

12. Enter the travel time requested for this PA grant period. (The maximum allowable quantity of travel time is the time actually required for travel from either the office and home, or the previous appointment and home, whichever is less.)

Certified Psychotherapist / Substance Abuse Counselor	**Second Team Member**
Total Number of Visits: _____	Total Number of Visits: _____
Travel Time per Visit x _____ Hours	Travel Time per Visit x _____ Hours
Total Travel Time = _____ Hours	Total Travel Time = _____ Hours

Continued

SECTION IV — SEVERELY EMOTIONALLY DISTURBED CRITERIA

13. Complete the checklist to determine whether or not the individual meets the criteria for SED. Criteria for meeting the functional symptoms and impairments are found in the instructions. The disability must be evidenced by a, b, c, and d listed below.

a. A primary psychiatric diagnosis of mental illness or SED. Document diagnosis using the most recent version of the *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).

❑ Primary Diagnosis: _____.

b. The individual must meet all three of the following.

❑ Be under the age of 21.
❑ Have emotional and behavioral problems that are severe in nature.
❑ This disability is expected to persist for a year or longer.

c. The individual must have one symptom or two functional impairments.

1. Symptoms (must have one).
   ❑ Psychotic symptoms.
   ❑ Suicidality.
   ❑ Violence.

2. Functional impairments (must have two).
   ❑ Functioning in self care.
   ❑ Functioning in the community.
   ❑ Functioning in social relationships.
   ❑ Functioning in the family.
   ❑ Functioning at school / work.

d. The individual is receiving services from one or more of the following service systems in addition to the mental health service system. (The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist, address the role of each system in the overall treatment and the major goals for each agency involved.)

❑ Social Services.
❑ Child Protective Services.
❑ Juvenile Justice.
❑ Special Education.

e. 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

14. Attach and label all of the following.

a. The Prior Authorization Request Form (PA/RF), F-11018.
b. The assessment and recovery/treatment plan.
c. A copy of a physician's prescription/order for in-home treatment services dated not more than one year prior to the requested first date of service (DOS).
d. Documentation that the member had a comprehensive HealthCheck screening performed by a valid HealthCheck screener dated not more than one year prior to the first DOS.
e. The Child and Adolescent Needs and Strengths assessment summary, Child and Adolescent Functional Assessment Scale, or the Achenbach Child Behavior checklist.
f. A substance abuse assessment may be included. A substance abuse assessment must be included if substance abuse-related programming is part of the member's treatment program.

SECTION VI — SIGNATURE

I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this attachment. I, or someone with comparable qualifications, will be available to the other team member(s) at all times when he or she is in the home alone working with the child/family.

15. **SIGNATURE —** Certified Psychotherapist / Substance Abuse Counselor	16. Credentials	17. Date Signed

ATTACHMENT 4
Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment Completion Instructions

(A copy of the "Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment Completion Instructions" is located on the following pages.)

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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
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 1-8 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.

ATTACHMENT 5
Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment

(A copy of the "Prior Authorization Intensive In-Home Mental Health/Substance Abuse Services Assessment and Recovery/Treatment Plan Attachment" is located on the following pages.)

FORWARDHEALTH

PRIOR AUTHORIZATION INTENSIVE IN-HOME MENTAL HEALTH / SUBSTANCE ABUSE SERVICES ASSESSMENT AND RECOVERY / TREATMENT PLAN ATTACHMENT

The use of this form is voluntary and optional and may be used in place of the member's assessment and recovery/treatment plans. 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 this form, 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.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member	3. Member Identification Number

SECTION II — INITIAL PRIOR AUTHORIZATION REQUEST

4. Date of Initial Assessment / Reassessment

5. Presenting Problem

6. Diagnoses, including all five axes (Use current *Diagnostic and Statistical Manual of Mental Disorders* [DSM] / *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3] code and description.)

   Axis I _____

   Axis II _____

   Axis III _____

   Axis IV (List psychosocial/environmental problems.) _____

   Axis V (Current Global Assessment of Functioning [GAF].) _____

7. Symptoms (List member's symptoms in support of given DSM / DC:0-3 diagnoses.)

   Severity of Symptoms ❒ Mild ❒ Moderate ❒ Severe

8. Strength-Based Assessment (Member strengths, and 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. An assessment dated within three months of the request may be attached.)

9. Describe the member's and caregiver's unique perspectives and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle, areas of functional impairment, family and community support.

10. Describe anticipated barriers / strengths toward member's progress and improved functioning.

11. Has there been a consultation to clarify diagnosis / treatment? ❒ Yes ❒ No
    If yes, by whom?
    ❒ Psychiatrist ❒ Ph.D. Psychologist ❒ Master's-Level Psychotherapist
    ❒ Advanced Practice Nurse Prescriber-Psychiatry / Mental Health Specialty
    ❒ Substance Abuse Counselor ❒ Other (Specify) _____

    Date of Latest Consultation _____
    ❒ Attach report.

Continued

SECTION III — SUBSEQUENT PRIOR AUTHORIZATION REQUESTS

12. Indicate any changes in Elements 1-8, including the current Global Assessment of Functioning, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status.

13. Describe current symptoms / problems.

- ❒ Anxiousness
- ❒ Appetite Disruption
- ❒ Decreased Energy
- ❒ Delusions
- ❒ Depressed Mood
- ❒ Disruption of Thoughts
- ❒ Dissociation
- ❒ Elevated Mood
- ❒ Guilt
- ❒ Hallucinations
- ❒ Homicidal
- ❒ Hopelessness
- ❒ Hyperactivity
- ❒ Impaired Concentration
- ❒ Impaired Memory
- ❒ Impulsiveness
- ❒ Irritability
- ❒ Manic
- ❒ Obsessions / Compulsions
- ❒ Oppositional
- ❒ Panic Attacks
- ❒ Paranoia
- ❒ Phobias
- ❒ Police Contact
- ❒ Poor Judgment
- ❒ School Problems
- ❒ Self-Injury
- ❒ Sexual Issues
- ❒ Sleeplessness
- ❒ Somatic Complaints
- ❒ Substance Use
- ❒ Suicidal
- ❒ Tangential
- ❒ Tearful
- ❒ Violence
- ❒ Worthlessness

❒ Other _____

SECTION IV — IN-HOME RECOVERY / TREATMENT PLAN

Document the goals and specific objectives to meet those goals on the recovery/treatment plan that is based on the strength-based assessment. Document the signs of improved functioning that will be used to measure progress toward specific objectives at identified intervals, agreed upon by the provider and member.

14. Treatment plan, as agreed upon with the member.

Short term (Three months) _____

Long term (Within the next year) _____

	What are the therapist / member agreed-upon signs of improved functioning?	Describe progress since last review.	Changes in Goal / Objective
1.			
2.			
3.			
4.			

Continued

SECTION IV — IN-HOME RECOVERY / TREATMENT PLAN (Continued)

15. How are member's strengths being utilized?

16. Indicate the rationale for in-home treatment. For an initial prior authorization (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 treatment is needed and how the provider plans to address the need for continued treatment. What strategies will the provider, as the therapist, use to assist the member in meeting his or her goals? If progress is reported, give rationale for continued services.

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.

18. Is member taking any psychoactive medication? ❒ Yes ❒ No

Name / Credentials of Prescriber _____

Date of Last Medication Check _____

19. If yes, list psychoactive medications and dosages.

Medication and Dosages _____ Target Symptoms _____

Medication and Dosages _____ Target Symptoms _____

Medication and Dosages _____ Target Symptoms _____

Is informed consent current for all medications? ❒ Yes ❒ No

SECTION V — MULTI-AGENCY TREATMENT PLAN

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.

20. Individual Coordinating the Multi-agency Planning

A.	**Social Services Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member (s) responsible.)

Describe progress since last review.

B.	**Child Protective Services Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

Continued

SECTION V — MULTI-AGENCY TREATMENT PLAN (Continued)

C.	**School Agency**	Names — Agency Team Members

Current Special Education Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

D.	**Juvenile Justice Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

E.	**Other Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

SECTION VI — SIGNATURES

21. **SIGNATURE** — Certified Psychotherapist / Substance Abuse Counselor	22. Credentials	23. Date Signed
24. **SIGNATURE** — Member / Legal Guardian		25. Date Signed