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# WISCONSIN MEDICAID UPDATE

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FEBRUARY 20, 1995

UPDATE 95-6

TO:  
In-Home Treatment  
Providers

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## **In-Home Treatment Under HealthCheck "Other Services" Prior Authorization: Changes to Requirements, PA/ITA Attachment, and Instructions - Effective January 1, 1995**

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### **All Prior Authorization Grant Periods May Be Up to 13 Weeks**

We will now authorize the initial grant period for up to 13 weeks. In the past, we authorized only up to eight weeks.

After the initial request, we will authorize subsequent requests up to 13 weeks.

### **Prior Authorization Up to 104 Hours During Grant Period**

We will authorize up to 104 hours of direct service to the family during the grant period (an average of eight hours per week), but you may use the hours flexibly. That is, you may provide 10 hours of direct service one week and six hours another, as long as you stay within the 104 hours during the grant period.

When two therapists provide services together to the family for one hour, this is considered one hour of direct service to the family.

You must still identify the planned weekly service hours on your prior authorization request.

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### **Medicaid-Certifiable Psychologist May Sign the Treatment Plan**

Previously, we required that treatment plans be signed by a psychiatrist. Now, a Medicaid-certifiable psychologist (one who is licensed in Wisconsin and listed or eligible to be listed in the National Register of Health Care Providers in Psychology) may sign the recipient's diagnosis and treatment plans.

A physician must still sign the plan if the recipient is receiving medication or if the Medicaid consultant requested that a physician or psychiatrist review the plan.

A physician's prescription (this need not be a psychiatrist) is still required for in-home services.

### **Revised PA/ITA Attachment and Instructions**

A revised PA/ITA (Prior Authorization Intensive In-Home Treatment Attachment) and instructions are attached. The instructions contain additional guidance on how to complete the PA/ITA. You may order additional copies from EDS, Attn: Form Reorder, 6404 Bridge Road, Madison, WI 53784-0003.

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Issued by Bureau of Health Care Financing, Wisconsin Division of Health  
If you have any questions, call EDS - Medicaid Fiscal Agent at (800) 947-9627 or (608) 221-9883

**INSTRUCTIONS AND GUIDELINES  
FOR COMPLETION OF THE PRIOR AUTHORIZATION  
INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)**

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The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS  
Prior Authorization Unit  
Suite 88  
6406 Bridge Road  
Madison, WI 53784-0088

**GENERAL INSTRUCTIONS**

The information contained on this Prior Authorization In-Home Treatment Attachment (PA/ITA) will be used to make a decision about the amount of intensive in-home treatment which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible. Where noted in these instructions, you may attach material which you may have in your records.

In-home services are generally deemed appropriate for children who meet the criteria of being severely emotionally disturbed (see Section III-C). The provider must also justify the appropriateness of providing the services in the home rather than in the clinic setting. The unique needs of an SED child and his or her family necessitate a team approach. For purposes of Medical Assistance reimbursement this team must be led by a Medical Assistance-certified psychotherapy provider.

**Initial Prior Authorization Request**

Please complete the PA/RF and the entire in-home treatment attachment. The initial authorization will be for a period of no longer than 13 weeks.

**First Reauthorization**

Please complete the PA/RF and pages 1 and 2 of the prior authorization in-home treatment attachment. Attach a copy of the HealthCheck verification which was included with the initial authorization. Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan. Authorization may be granted for up to 13 weeks.

**Subsequent Reauthorizations**

Please complete the PA/RF and pages 1 and 2 of the PA/ITA. Attach a copy of the HealthCheck verification which was included with the initial authorization. An updated multi-agency treatment plan and an updated screening (Achenbach or CAFAS) using the

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same screening tool used for the initial request must be completed at six-month intervals from the time of the initial request. Summarize the treatment since the previous authorization. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of in-home treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Discuss plans for terminating in-home treatment and the services which the recipient/family will require. Authorization will be for a period of no longer than 13 weeks.

***Please check the appropriate box at the top of the PA/ITA to indicate whether this request is an initial, first reauthorization, second reauthorization or subsequent request. Make sure that the appropriate materials are included for the type of request indicated.***

**Additional Considerations for In-Home Treatment for AODA**

When alcohol and other drug abuse treatment issues are identified as part of the in-home treatment plan, an appropriately qualified AODA counselor must be identified as part of the treatment team. In-home treatment by a team headed by an AODA counselor (without a certified psychotherapist participating) will generally not be approved. In these instances the provider must document the absence of significant psychopathology and the primary goal of intervention must be motivational with a goal of getting the recipient and/or family involved in traditional outpatient services.

**Multiple Services**

When a recipient will require prior authorization for other services concurrent to the in-home treatment (e.g., mental health or AODA day treatment), a separate PA/RF must be submitted for those services and the appropriate prior authorization attachment and all required materials must be submitted for that other service. Please indicate on this prior authorization request that services will be coordinated with the other service provider (if the service will be provided by a different agency). These other services must be identified on the multi-agency treatment plan.

**SECTION I**

**ELEMENTS 1-4 - RECIPIENT INFORMATION**

Enter the recipient's last name, first name, middle initial, and 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

**ELEMENT 5 - RECIPIENT'S AGE**

Enter the age of the recipient in numerical form (e.g., 21,45,60, etc.).



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with certified therapist plus one hour - two times a week for 13 weeks for the second team member independently. More than 104 hours of direct treatment to the family during a 13-week period will not be authorized.

- C. Indicate the number of hours the certified psychotherapist will provide direct treatment services to the family and the number of hours that the second team member will provide direct treatment to the family. If more than two providers will be involved in providing services, document that all individuals meet the criteria in these guidelines. Total hours of treatment must not exceed the limitation noted in "B" (above). Reimbursement is not allowed for more than two providers for the same treatment session. Since two providers may be providing services at the same time, on occasion, the total hours in this section may exceed the number of hours of treatment the family will receive as noted in B. 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 members), special justification should be noted on the request.

Please indicate the name and qualifications of the second team member. Attach a resume, if available. The minimal qualifications must be:

- An individual who possesses at least a bachelor's degree in a behavioral science, an RN, an OT, a Medical Assistance-certified AODA counselor or a professional with equivalent training. The second team member must have at least 1000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth, or;
- Other individuals who have had at least 2000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- The second team member will be reimbursed at a lower rate, even if that person is a certified Medical Assistance psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

If the second team member is a Medical Assistance certified psychotherapy provider, only their Medical Assistance provider number need be entered to document their qualifications.

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- D. 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 recipient's home or from the previous appointment to the recipient's home. Travel time exceeding one hour one-way will generally not be authorized.

**SECTION III**

- A. Present a summary of the mental health assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of DSM-III-R are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. The assessment summary should provide documentation supporting the diagnosis. A psychiatrist or psychologist\* must review and sign the summary and diagnosis indicating their agreement with the results. In those cases where the only, or

\*In all instances, psychologist means one who meets the criteria for Medical Assistance certification at the Ph.D. psychologist level: Licensed in Wisconsin and listed or eligible to be listed in the national register of health care providers in psychology.

primary, diagnosis is a conduct disorder, the request must provide sufficient justification for the appropriateness of in-home treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of an in-home intervention (see "Additional Considerations for In-Home Treatment for AODA" in the General Instructions). Providers may attach copies of an existing assessment if it is no longer than two pages.

- B. Present a summary of the recipient's illness/treatment/medication history. In those cases where the recipient has spent significant amounts of time out of the home, or is out of the home at the time of the request, the treatment plan must specifically address the transition, reintegration and attachment issues. For individuals with significant substance abuse problems, the multi-agency treatment plan must address how these will be addressed. For individuals 16 years and over who have spent significant amounts of time out of the home, the request must discuss why intensive in-home treatment is preferred over preparing the recipient for independent living. Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.
- C. Complete the checklist for determining that an individual meets the criteria for severe emotional disturbance. The following information defines the allowable conditions for Parts 2 and 3 of the checklist.

For Part 2, the individual must have one of the following diagnoses from the most recent version of DSM-III-R.

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Adult diagnostic categories appropriate for children and adolescents are:

organic mental syndromes and disorders (292.00\* - 292.90\*, 294.80)  
psychoactive substance use disorders (303.90, 304.00 - 304.90\*, 305.00, 305.20\* - 305.90\*) (use codes for *abuse only*)  
schizophrenia (295.1x, 295.2x, 295.3x, 295.6x, 295.9x)  
schizoaffective disorders (295.70)  
mood disorders (296.2x - 296.70, 300.40, 301.13, 311.00)  
somatoform disorders (300.11, 300.70\*, 300.81, 307.80)  
dissociative disorders (300.12 - 300.15, 300.60)  
sexual disorders (302.20 - 302.40, 302.70 - 302.79, 302.81 - 302.84, 302.89, 302.90, 306.51)  
intermittent explosive disorder (312.34)  
pyromania (312.33)  
adjustment disorder (309.00, 309.23 - 309.90)  
personality disorders (coded on Axis II: 301.00, 301.20 - 301.50, 301.60 - 301.90)  
psychological factors affecting physical condition (316.00 - *and specify physical condition on Axis III*)

Disorders usually first evident in infancy, childhood and adolescence include:

pervasive developmental disorders (coded on Axis II: 299.00, 299.80)  
disruptive behavior disorders (312.00, 312.20, 312.90, 313.81, 314.01)  
anxiety disorders of childhood or adolescence (309.21, 313.00, 313.21)  
eating disorders (307.10, 307.50, 307.51, 307.52, 307.53)  
gender identity disorders (302.50, 302.60, 302.85\*)  
tic disorders (307.20 - 307.23)  
reactive attachment disorder of infancy or early childhood (313.89)

For Part 3, the symptoms and impairments are defined as follows.

**SYMPTOMS**

- 1) Psychotic symptoms - serious mental illness (e.g. schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
- 2) Suicidality - The individual must have made one attempt within the last three months or have significant ideation about or have a plan for suicide within the past month.
- 3) Violence - The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

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**FUNCTIONAL IMPAIRMENT** (compared with expected developmental level):

- 1) 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.
  - 2) Functioning in community - Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement in the juvenile justice system.
  - 3) Functioning in social relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
  - 4) 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 which may result in removal from the family or its equivalent.
  - 5) 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 - e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others; or
    - b) meeting the definition of "child with exceptional educational needs" under ch. PI 11 and 115.76(3) Wis. Stats.; or
    - c) Impairment at work is the inability to be consistently employed at a self-sustaining level - e.g. inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job.
- D. Present an assessment of the family's strengths and weaknesses. Present evidence that the family is willing to be involved in treatment and is capable of benefiting from treatment. Where the presence of significant psychological dysfunctioning or alcohol and other drug abuse problems is indicated among family members, please indicate on the multi-agency treatment plan how these problems will be addressed.

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Reimbursement for treatment services primarily directed at recipients over the age of 20 are not available through HealthCheck "Other Services," except as noted in Section IV-D. Indicate which family members will be involved in treatment. If an assessment of the family's willingness and ability to be involved in treatment is an initial treatment goal please indicate this with at least minimal justification for believing this to be the case. If a family assessment is contained in the psychiatric evaluation or illness/treatment history, please indicate this.

- E. The provider must specifically identify the rationale for providing services in the home for this child/family. A significant history of failed outpatient treatment along with documentation which identifies a significant risk of out-of-home placement will support such a request. Strong justification is needed if outpatient clinic services have not been previously utilized. The provider should identify specific barriers to the family receiving treatment in a clinic setting or specific advantages for this family receiving services in the home (not simply general advantages of in-home treatment). The provider should present this justification in their own words and not assume that the consultant can infer this from other information submitted with this request.
  
- F. Indicate the expected duration of in-home treatment. Describe services expected to be needed following completion of in-home treatment and transition plans. While providers are expected to indicate their expectations on the initial requests it is critical that plans for terminating in-home treatment be discussed in any authorizations for services at and beyond six months of treatment.

**SECTION IV**

- A. The prior authorization request form (PA/RF) may be obtained from EDS. Use process type 129 in element 1. The words "HealthCheck Other Services" should be written in red across the top of the form. Providers should use the following procedure codes and descriptions in elements 14 and 18:

W7027	In-Home Treatment: Certified Psychotherapist
W7028	In-Home Treatment: Second Team Member
W7029	Travel Time: Certified Psychotherapist
W7030	Travel Time: Second Team Member

The quantity requested in element 19 should represent total hours for the grant period requested and element 20 should represent charges for all hours indicated in element 19. Element 16, place of service is "4" (home) for W7027 and W7028 and "0" (other) for W7029 and W7030. Element 17, type of service, is "1" for all codes.

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- B. The request must include documentation that the recipient had a comprehensive HealthCheck screening within one year of the date the request is received at EDS. This documentation must be one of the following:
- A copy of the HealthCheck verification card showing a comprehensive screen in the past year;
  - a copy of the HealthCheck provider's billing form showing a claim for a comprehensive HealthCheck screening (procedure code W7000);
  - a copy of the HealthCheck provider's remittance and status report 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 on the recipient; or
  - a physician's prescription for the service with a note on the prescription that this is subsequent to a comprehensive HealthCheck screening performed at their practice and the date of the screen.

If the recipient is present for a HealthCheck screening and is uncooperative with part or all of the screening, documentation from the HealthCheck provider should be attached and will be adequate for accessing the in-home services.

- C. The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist. The plan must address the role of each system in the overall treatment and the major goals for each agency involved. The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning the provider must document the reason and what attempts were made to include them. The plan should indicate why services in the home are necessary and desirable. The individual who is coordinating the multi-agency planning should be clearly identified. A psychiatrist or psychologist must sign either the multi-agency plan or in-home treatment plan. A physician should sign off on the multi-agency plan if the recipient is taking medication. A model plan may be obtained by writing to the SED coordinator at:

SED Coordinator  
Division of Community Services  
Office of Mental Health  
Post Office Box 7851  
Madison, WI 53707-7851  
(608) 266-6838; Fax: (608) 266-0036

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If a plan other than the model plan is used, all the information on the model must be included.

- D. The in-home treatment team must complete a treatment plan covering their services. A psychiatrist or psychologist must sign either the in-home treatment plan or the multi-agency treatment plan. Providers may obtain a copy of a model plan from the SED Coordinator or use one of their own which provides equivalent information. 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 Medical Assistance-covered services. Services which are primarily social or recreational in nature are not reimbursable. The plan should clearly identify which team members are providing the Medical Assistance-covered services being requested.

Services provided to the recipient's parents, foster parents, siblings, or other individuals significantly involved with the recipient are deemed appropriate as part of the in-home treatment plan when these services are required to directly affect the recipient's functioning at home or in the community. Such services include family therapy necessary to deal with issues of family dysfunctioning, behavior training with responsible adults to identify problem behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with the family members which are necessary to ensure their ability to continue their participation in the in-home treatment process. Interventions with family members or significant others which are primarily for the benefit of these others are not reimbursable under these guidelines, except where these other individuals meet the criteria for intensive in-home treatment (e.g., they are 20 years of age or under) and authorization has been received for these other services under these guidelines. For instance, intervention directed solely at a parent's alcohol abuse is considered AODA treatment, is covered by the policy for AODA treatment service, and is not reimbursable in the home. However, when the intervention is with the whole family and is focusing on the way in which the parent's alcohol abuse is affecting the child and/or contributing to the problem behaviors, this may be authorized under these guidelines.

Initial treatment goals may include assessment of the recipient and family in the home and these goals may be procedural (e.g., complete assessment, have all members of family attend 75% of meetings, complete AODA assessment). Where an assessment is part of the initial intervention, be concrete as to the components of the assessment (e.g. psychiatrist will complete psychiatric evaluation, AODA counselor will complete substance abuse assessment). Where appropriate, identify any standardized assessment tools that will be utilized.

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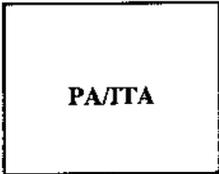
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- E. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS). Additional information about these screening instruments can be obtained from the SED Coordinator at the address noted above.
  
- F. An AODA assessment must be included if AODA related programming is part of the recipient's treatment program. The assessment may be summarized in Section III- A or -B as part of the psychiatric assessment or illness history.
  
- G. Attach a physician's prescription for in-home treatment services.

The request must be signed and dated by the certified psychotherapy provider who is leading the in-home treatment team. It must also be signed and dated by the supervising therapist if the certified psychotherapy provider is not a PhD. psychologist or psychiatrist. In signing, these individuals accept 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 Medical Assistance certified psychotherapy provider will be available to the other team members when they are in the home alone with the child/family.

Check One:  initial request  subsequent reauthorization  
 first reauthorization

MAIL TO: EDS  
Prior Authorization Unit  
Suite 88  
6406 Bridge Road  
Madison, WI 53784-0088



1. Complete this form.
2. Attach PA/RF.
3. Attach all requested information.
4. Attach prescription.
5. Mail to EDS.

**PRIOR AUTHORIZATION  
INTENSIVE IN-HOME TREATMENT**

Providers should carefully read the attached instructions before completing this form.

**SECTION I.**

**RECIPIENT INFORMATION**

(1)	(2)	(3)	(4)	(5)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name	First Name	MI	Medical Assistance Identification #	Age

**PROVIDER INFORMATION**

(6)	(7)
<input type="text"/>	<input type="text"/>
Certified Clinic Name	Medical Assistance Provider #
(8)	(9)
<input type="text"/>	<input type="text"/>
Certified Performing Psychotherapist's Name	Medical Assistance Provider #
(10)	(11)
<input type="text"/>	<input type="text"/>
Psychotherapist's Telephone #	Discipline

**SECTION II.**

A. Requested start date and end date for this authorization period. See instructions for maximum allowable authorization guidelines. If start date is prior to when request will be received at EDS, please indicate clinical rationale.

B. Number of hours of treatment to be provided to family over this PA grant period. Please note anticipated pattern of treatment by provider (e.g., two hours - one time per week by certified therapist, two hours - one time per week by family aide with certified therapist plus one hour - two times a week by family aide independently).

C. Please indicate for the period covered by this request:

The number of hours the certified psychotherapist will provide treatment \_\_\_\_\_

The number of hours the second team member will provide treatment \_\_\_\_\_

The name and credentials of the second team member. Include degree and number of hours of supervised clinical work with SED children (attach resume, if available):

D. Please indicate the travel time for the period covered by this request:

certified psychotherapist

anticipated number of visits \_\_\_\_\_

X travel time per visit \_\_\_\_\_

= \_\_\_\_\_

other therapist

anticipated number of visits \_\_\_\_\_

X travel time per visit \_\_\_\_\_

= \_\_\_\_\_

**SECTION III.**

The following additional information must be provided. If you attach copies of existing records to provide the information requested please limit attachments to two pages for the psychiatric evaluation and illness/treatment history. Highlighting relevant information is helpful. Do not attach M-team summaries, additional social service reports, court reports, or other similar documents unless directed to do so following initial review of the documentation.

- A. Present a summary of the recipient's psychiatric assessment and differential diagnosis. Diagnoses on all five axes of DSM-III-R are required. The summary must also present adequate information to support the diagnosis. A psychiatrist or Ph.D. psychologist\* must review and sign the summary and diagnoses.

\* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of healthcare providers in psychology.

- B. Present a summary of the recipient's illness/treatment/medication history and other significant background information. Define the potential for change. Note if the child is currently in out-of-home placement and, if so, the timeline for reintegration.

C. Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. SED in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must be evidenced by 1, 2, 3 and 4 listed below.

1. **The individual must meet all three of the following:**

- a. be under the age of 21;
- b. have an emotional disability that has persisted for at least six months; and
- c. that same disability must be expected to persist for a year or longer.

2. **A condition of severe emotional disturbance** as defined by a mental or emotional disturbance listed in the most recent version of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

\_\_\_\_\_  
Primary Diagnosis

3. **Functional Symptoms and Impairments**

The individual must have A. or B.

a. **Symptoms** (must have one)

- 1. Psychotic symptoms
- 2. Suicidality
- 3. Violence

b. **Functional impairments** (must have two)

- 1. Functioning in self care
- 2. Functioning in the community
- 3. Functioning in social relationships
- 4. Functioning in the family
- 5. Functioning at school/work

4. **The individual is receiving services from two or more of the following service systems.**

- Mental Health
- Social Services
- Child Protective Services
- Juvenile Justice
- Special Education

**Eligibility Criteria Waived Under Certain Circumstances:**

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system but in the judgment of the medical consultant, would be likely to do so where the intensity of treatment requested was not provided. Attach explanation.
- This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, but in the judgment of the medical consultant, the nature of the acute episode is such an impairment in functioning (as defined in the "Severe Emotional Disturbance Criteria Checklist," January 29, 1992) that it is likely to be evident without the intensity of the treatment requested. Attach explanation.

D. Present an assessment of the family's strengths and weaknesses.

E. Indicate the rationale for in-home treatment. Elaborate on this choice where prior outpatient treatment is absent or limited.

F. Indicate the expected date for termination of in-home treatment. Describe anticipated services needs following completion of in-home treatment and transition plans.

**SECTION IV.**

Please attach and label the following:

- A. The prior authorization request form (PA/RF).
- B. Documentation that the recipient had a comprehensive HealthCheck screening within the past year.  
*A copy of this documentation must be attached to all requests for reauthorizations (a copy of the original documentation may be used).  
**The initial request for these services must be received by EDS within one year of when the HealthCheck screening was dated.***
- C. A multi-agency treatment plan.
- D. An in-home psychotherapy treatment plan.
- E. Results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS).
- F. An AODA assessment may be included. An AODA assessment must be included if AODA related programming is part of the recipient's treatment program.
- G. A physician's prescription for in-home treatment service.

I attest to the accuracy of the information on this prior authorization 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 they are in the home alone working with the child/family.

\_\_\_\_\_  
**Signature of Certified Therapist**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Supervising Therapist**

\_\_\_\_\_  
**Date**