DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11040 (12/2019)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.22

FORWARDHEALTH

PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA)

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) Instructions, F-11040A. Providers may submit prior authorization (PA) requests by fax to ForwardHealth at 608-221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

❑ Initial Request ❑ First Reauthorization ❑ Second Reauthorization ❑ Subsequent Reauthorization

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)	2. Age – Member
3. Member ID Number	

SECTION II – PROVIDER INFORMATION

4. Name – Day Treatment Provider	5. Day Treatment Provider's National Provider Identifier
6. Name – Contact Person	7. Phone Number – Contact Person

SECTION III – DOCUMENTATION

8. Indicate the requested start date and end date for this authorization period. If the requested start date is earlier than the date the PA request is first received by ForwardHealth, specifically request backdating and state clinical rationale for starting services before PA is obtained.

9. Indicate the number of hours of treatment to be provided over the PA grant period. Indicate the pattern of treatment (for example, three hours per day, three days per week for eight weeks).

The following additional information must be provided. If copies of existing records are attached to provide the information requested, **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 similar documents unless directed to do so following initial review of the documentation.**

10. Present a summary of the member's diagnostic assessment and differential diagnosis. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. **Diagnoses on all five axes of the most recent American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) are required.**

11. Summarize the member's illness / treatment / medication history and other significant background information. Indicate why the provider thinks day treatment will produce positive change.

12. Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (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 severe emotional disorder**
Document diagnosis using the most recent version of the APA DSM.

Primary Diagnosis Code and Description: _____

b. **The individual must meet all three of the following conditions:**
- ❑ Individual is under the age of 21.
- ❑ Individual's emotional and behavioral problems are severe in nature.
- ❑ The disability for which the individual is seeking treatment is expected to persist for a year or longer.

c. **Symptoms and functional impairments**
The individual must have one of the following symptoms or two of the following functional impairments:

1. Symptoms
   - ❑ Psychotic symptoms
   - ❑ Suicidality
   - ❑ Violence

2. Functional impairments
   - ❑ Functioning in self care
   - ❑ Functioning in the community
   - ❑ Functioning in social relationships
   - ❑ Functioning in the family
   - ❑ Functioning at school / work

d. **The individual must be receiving services from two or more of the following service systems:**
- ❑ Mental health
- ❑ Social services
- ❑ Child protective services
- ❑ Juvenile justice
- ❑ Special education

Eligibility criteria are waived under the following circumstances:

- ❑ The individual substantially meets the criteria for SED, except that the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach an explanation.
- ❑ The individual substantially meets the criteria for SED, except that 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.

13. Describe the treatment program that will be provided. Attach a day treatment program schedule, if available. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this member's treatment goals.

14. Indicate the rationale for day treatment. Elaborate on this choice if prior outpatient (clinic) treatment is absent or limited. Why does the member need this level of intervention at this time?

15. Indicate the expected date for termination of day treatment. Describe the anticipated service needs following completion of day treatment and the transition plan.

SECTION IV – ATTACHMENTS AND SIGNATURE

16. The following materials must be attached and **labeled***:*

a. Attach a copy of a physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist, dated not more than one year prior to the requested first date of service (DOS).
b. Attach a multidisciplinary day treatment services plan. The treatment plan must be signed by a psychiatrist or psychologist.* Per Wis. Admin. Code § DHS 40.10(4), a psychiatrist or Ph.D. psychologist shall sign the treatment plan, signifying the services identified in the plan are necessary to meet the mental health needs of the child. Revisions in treatment plans also need to be approved by the program psychiatrist or Ph.D. psychologist.
c. 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.

I attest to the accuracy of the information on this PA request.

17. **SIGNATURE** – Day Treatment Program Director	18. Date Signed

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

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