FORWARDHEALTH

PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA) 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 procedures/services/items. 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/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), F-11038, to the Prior Authorization Request Form (PA/RF), F-11018, and Section I of the Mental Health Day Treatment Functional Assessment, F-11090, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests electronically via the ForwardHealth Portal by accessing *www.forwardhealth.wi.gov/,* by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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

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 — Age — Member
Enter the age of the member in numerical form (e.g., 21, 60).

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 and Credentials — Requesting / Rendering Provider
Enter the name and credentials of the therapist who will be providing treatment.

Element 5 — Requesting / Rendering Provider's National Provider Identifier (NPI) (not required)

Element 6 — Telephone Number — Requesting / Rendering Provider
Enter the rendering provider's telephone number, including area code.

SECTION III — DOCUMENTATION

Per DHS 101.03(37), Wis. Admin. Code, "Adult Mental Health Day Treatment" is described by the following definition:

> "Day treatment" or "day hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies, and follow-up services, to alleviate problems related to mental illness or emotional disturbances.

Note: Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills, and problem-solving skills.

Element 7 — Number of Hours per Week Requested
Enter the number of hours requested per week.

Element 8 — Estimated Final Treatment Date
Enter the estimated final treatment date.

Element 9
Indicate whether or not the member has had previous day treatment at the provider's facility or elsewhere.

Element 10 — Evaluation(s)
Describe evaluation(s), including date(s), tests used, and results.

Element 11
Attach Section I of the member's most recent functional assessment. (The Mental Health Day Treatment Functional Assessment must be signed and dated within three months of receipt by ForwardHealth.)

Element 12
Indicate whether or not the member's intellectual functioning is below average.

Element 13
Provide a brief history pertinent to requested services. (Include psycho-social history, hospitalization history, family history, living situation history, etc.).

Element 14
Describe progress/status since treatment began or was last authorized, if applicable.

Element 15
Specify overall character of the service to be provided.

Rehabilitation. This category is used for all of the adult mental health day treatment population who may benefit from **intensive** adult mental health day treatment.

Maintenance. This category is for those members who, by diagnosis and history, are suffering from a **chronic mental disorder** as indicated by diagnosis, signs of illness for two or more years, and past intensive adult mental health day treatment that has already been tried for six months or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment is to **maintain** the individual in the community and prevent hospitalization.

Stabilization. This category is for those members who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure, stabilize the member, prevent harm to self and/or others, and/or prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days), and/or other acceptable signs of a clear deterioration (in level and course of functioning).

Element 16
Identify measurable treatment goals.

Element 17
Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

Element 18
Estimate the member's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Element 19 — Signature — Member or Representative
Enter the signature of the member or representative.

Element 20 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/CCYY format) by the member or representative.

Element 21 — Relationship (If Representative)
Include relationship to member (if a representative signs).

Element 22 — Signature — Therapist Providing Treatment
Enter the signature of the therapist providing treatment.

Element 23 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/CCYY format) by the therapist providing the treatment.

Element 24 — Signature — 51.42 Board Director / Designee (No Longer Required)

Element 25 — Date Signed (No Longer Required)