ATTACHMENT 3

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

COMPLETION INSTRUCTIONS

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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:

E.D.S. Federal Corporation
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 an MA 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 eight weeks and will allow the provider to further assess the family and determine their willingness and ability to continue in treatment.

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 referral form 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. If changes were made to the treatment plan, send a copy of the amended or updated plan. Authorization may be granted up through the sixth month of treatment.

Six month reauthorization: Please complete the PA/RF and pages 1 and 2 of the PA/ITA. Attach a copy of the HealthCheck referral form which was included with the initial authorization request. There should also be an updated multi-agency treatment plan and an updated screening (Achenbach or CAFAS) using the same screening tool used for the initial request. Summarize the treatment since the previous authorization. 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. Authorization will be for a period of no longer than three months.

Subsequent reauthorizations: Please complete the PA/RF and pages 1 and 2 of the prior authorization in-home treatment attachment. Attach a summary of the treatment to date and a revised in-home treatment plan. Note progress on short- and long-term goals from the original plan. Discuss the plans for terminating in-home treatment and what services will be required following the completion of in-home treatment. 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. Authorizations for up to three months may be allowed.

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.
RECIPIENT INFORMATION

Elements 1-4. 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.).

PROVIDER INFORMATION

Element 6. CERTIFIED CLINIC NAME
Enter the name of the Medical Assistance certified psychotherapy clinic which will be billing for the services.

Element 7. CLINIC PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the clinic which will be billing for in-home treatment.

Element 8. CERTIFIED PSYCHOTHERAPIST'S NAME
Enter the name of the Medical Assistance certified psychotherapist who will be the lead member of the team providing services. Master's level psychotherapists must obtain an MA performing provider number in order to bill for these services even if this is not ordinarily required for the type of facility by which they are employed.

Element 9. THERAPIST'S PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the certified psychotherapist identified in element 8.

Element 10. THERAPIST'S PHONE NUMBER
Enter the telephone number, including area code, of the certified psychotherapist identified in element 8.

Element 11. THERAPIST'S DISCIPLINE
Enter the discipline of the certified psychotherapist identified in element 8 (e.g., MSW, PhD., etc.).

SECTION II.

A. Enter the requested start date and end date for this authorization request. The initial authorization may be backdated up to 10 working days prior to the receipt of the request at EDS if the provider documents the clinical need for beginning services immediately. Please note guidelines for length of authorizations under the "General Instructions" above.

B. Enter the total expected number of hours the family will receive direct treatment services over this prior authorization grant period. When two therapists are present at the same time, this is still counted as one hour of treatment received by the family. Also indicate the anticipated pattern of treatment for each team member, e.g., 2 hours-one time a week for 8 weeks by the certified psychotherapist, 2 hours one time per week by the second team member with certified therapist plus 1 hour-2 times a week for 8 weeks for the second team member independently. More than eight hours per week of direct treatment to the family will generally 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. Reimbursement is limited to two individuals for any family. Since both 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. It is expected that the primary psychotherapist will be involved in treatment about 30% of the time. If the primary psychotherapist is involved in treatment more than 50% of the time, 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, an MA 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;
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> 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 MA psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

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 DSM-III-R are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. If not conducted by a psychiatrist, a psychiatrist must review and sign the summary and diagnosis indicating their agreement with the results. In those cases where the only, or 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 DSM-III-R diagnoses:
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.

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 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 how these problems will be addressed outside of the in-home treatment process (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. 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

B. A HealthCheck referral must accompany the request. When the request is for a reauthorization the provider should attach a copy of the initial HealthCheck referral. The initial request for this recipient must be received by EDS within six months of the date of the HealthCheck referral.

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 must sign either the multi-agency plan or in-home treatment plan. A model plan may be obtained by writing to the SED coordinator at:

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

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 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.

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 with complete substance abuse assessment. Where appropriate identify any standardized assessment tools that will be utilized.

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.

The request must be signed by the certified psychotherapy provider who is leading the in-home treatment team. It must also be signed 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 an MA certified psychotherapy provider will be available to the other team members when they are in the home alone with the child/family.