Clear Form

Minnesota Department of **Human Services**

DHS-4159A-ENG 12-11

Minnesota Health Care Programs (MHCP)

Adult Mental Health Rehabilitative Services Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form to request authorization for ARMHS, Day Treatment or IRTS when the diagnostic assessment, functional assessment, and individual treatment (rehabilitation) plan indicate the need for additional or concurrent medically necessary mental health services.

See instructions for completing this form on page 3.

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

Reason for this request (check all that apply)

- ☐ This service requires authorization before being provided
- ☐ This service authorization is required because of concurrent care
  - ☐ Name of concurrent service provider _____
  - ☐ Service _____
  - ☐ Referral (include as supporting documentation)
- ☐ The allowed maximum units for this service have been used or are expected to be used within 10 business days:
  - ☐ ARMHS Community Intervention (10 sessions/cal mo, or 72 sessions/cal yr), procedure code 90882
  - ☐ ARMHS Medication Education (26 hr/cal yr individual; 26 hr/cal yr group), procedure code H0034 (individual) or H0034 HQ (group)
  - ☐ ARMHS Basic Living and Social Skills (300 hr/cal yr), procedure code H2017 (individual) or H2017 HQ (group)
  - ☐ ARMHS Transition to Community Living, procedure code H2017UD, 90882UD
  - ☐ Adult Mental Health Day Treatment (115 hr/cal yr), procedure code H2012
  - ☐ Intensive Residential Treatment Services (IRTS) procedure code H0019 - 90 days per admission

Prior mental health service history (past 12 months) (check all that apply, include begin and end dates)

☐ Individual psychotherapy DATE: _____	☐ Partial hospitalization DATE: _____	☐ ACT DATE: _____	☐ Family psychotherapy DATE: _____
☐ Inpatient hospitalization DATE: _____	☐ Day treatment DATE: _____	☐ Group psychotherapy DATE: _____	☐ Emergency services DATE: _____
☐ IRTS DATE: _____	☐ Medication management DATE: _____	☐ Crisis response services DATE: _____	☐ ARMHS DATE: _____

☐ Other (describe) _____ ☐ Unknown

Recipient diagnosis

The recipient must have a diagnosis of mental illness and functional impairments that interfere with daily living that are caused by or exacerbated by the mental illness.

DATE OF CURRENT DIAGNOSTIC ASSESSMENT (DA) (must attach)	DATE OF CURRENT FUNCTIONAL ASSESSMENT (FA) (must attach)
DATE OF CURRENT INTERPRETIVE SUMMARY (IS) (must attach)	LOCUS DETERMINATION DATE (must attach)

Treatment (Rehabilitation) Plan/Treatment Review/Service Planning

MEDICAL NECESSITY FOR ADDITIONAL UNITS OF SERVICE

DISCHARGE CRITERIA AND PROJECTED DISCHARGE DATE

Indicate recipient's overall discharge plan and expected date of achievement.

PROJECTED DISCHARGE DATE

IRTS ONLY - DISCHARGE GOAL

Adult Mental Health Rehabilitative Services Authorization Form Instructions

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695). Complete all fields on this form.

Fax this form with supporting documentation to the medical review agent.

If you do not complete all fields or include supporting documentation, this request may be delayed or denied. See also Authorization and Mental Health Services for additional information.

Reason for this Request

Check the appropriate box(es) to explain the reason you need an authorization and attach any supporting documentation (such as a referral notice from an ACT team for day treatment services that describes the specific need for concurrent services).

Enter the name of the provider and the service, as appropriate if the authorization is required due to the provision of concurrent care.

In some cases, ARMHS, day treatment services, or IRTS must be authorized or prior authorized when provided concurrent with other services (i.e., when ARMHS Basic Living and Social Skills services are provided concurrently with Assertive Community Treatment (ACT) services.) It is expected that ARMHS and ACT will occur concurrently only during periods of transition as approved by the medical review agent.

Prior Mental Health Service History

Check each box that applies for all mental health services the recipient received in the past 12 months.

- Use the 'Other' box for any unlisted mental health service; include begin and end dates.
- Use the 'Unknown' box if you do not know of any of these services being provided in the past year
- Use the 'None' box only if you are certain no other services were provided to the individual

Treatment (Rehabilitation) Plan/Treatment Review/Service Planning

In addition to the treatment plan and progress notes, indicate other services from you or another provider serving the recipient during the plan period; include the type of service (1:1 or group), and responsible party.

For IRTS, include the discharge goal which identifies the functioning that must be restored for the recipient to successfully reenter into their post-IRTS environment.

Include the following and any other supporting documentation (such as referral, individual treatment plans, progress notes, interpretive/integrated summary) sufficient to indicate a history of the recipient's progress or other changes in mental health status:

- Proposed individualized treatment/rehabilitation plan and two (2) prior plans, if recipient received services from you before this request. For IRTS include the 2 previous/revised ITPs as well as the proposed ITP
- Progress notes for the past six (6) sessions or two (2) weeks, whichever is greater (for IRTS - 2 weeks)

Medical necessity for additional units of service: Explain how continuing services will benefit the recipient and support the findings of the interpretive summary.

Discharge criteria and projected date: Describe the outcomes the recipient must meet and the services and supports that need to be established, including referrals for other services and coordination for continuing care when indicated. Enter the realistic anticipated date of discharge, regardless of whether or not the date falls within the timeframe of the authorization request.