DEPARTMENT OF HUMAN SERVICES

DHS-4159A-ENG 5-23

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Adult Mental Health Rehabilitative Services Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form to request authorization for adult rehabilitative mental health services (ARMHS), Day Treatment or intensive residential treatment services (IRTS).

See instructions for completing this form on page 3.

Provider information

PROVIDER NAME	NPI or 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 requires authorization because of concurrent care
- ☐ The allowed maximum units for this service have been used or are expected to be used within 10 business days:
  - ☐ ARMHS Functional Assessment (6 units per calendar year), procedure code H0031
  - ☐ ARMHS Individual Treatment Plan (4 units per calendar year), procedure code H0032
  - ☐ ARMHS Community Intervention (10 sessions per calendar month, or 72 sessions per calendar year), procedure code 90882
  - ☐ ARMHS Medication Education (26 hours per calendar year individual; 26 hours per calendar year group), procedure code H0034 (individual) or H0034 HQ (group)
  - ☐ ARMHS Basic Living and Social Skills (300 hours per calendar year), procedure code H2017 (individual) or H2017 HQ (group)
  - ☐ ARMHS Transition to Community Living, procedure code H2017 UD, 90882 UD
  - ☐ Adult Mental Health Day Treatment (115 hours per calendar year), 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 start and end dates)

- ☐ ACT
- ☐ ARMHS
- ☐ Crisis response services
- ☐ Day treatment
- ☐ Dialectical behavior therapy (DBT)
- ☐ Emergency services
- ☐ Family psychotherapy
- ☐ Group psychotherapy
- ☐ Individual psychotherapy
- ☐ Inpatient hospitalization
- ☐ IRTS
- ☐ Medication management
- ☐ Mental health targeted case management
- ☐ Neuropsychological services
- ☐ Partial hospitalization
- ☐ Other
- ☐ Unknown
- ☐ None

List ICD-10 diagnosis

ICD-10	Diagnosis description

Include the following with your authorization request:

- Current diagnostic assessment (DA)
- Current functional assessment (FA)
- Current Level of Care Assessment (only if applicable)
- Current individual treatment plan (ITP)
- Progress notes for the past six sessions or two weeks, whichever is greater (for IRTS - two weeks)

In addition to the treatment plan, include:

- Indicate other services (from your agency or another provider serving the recipient) during the plan period. Include the type of service (one-on-one or group) and responsible party.
- Medical necessity for additional units of service
- Discharge criteria and projected discharge date

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.

Send 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 assertive community treatment (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. 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 start 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.

List ICD-10 diagnosis

List each ICD diagnosis for the recipient.

Attach the following

Attach each of the six items in the bulleted list.

Individual treatment plan (rehabilitation) and treatment review

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

- Proposed individualized treatment 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.