Adult Mental Health Rehabilitation Treatment Request Form

AmeriHealth Caritas Louisiana

Please print clearly. Incomplete or illegible forms will delay processing. Please return the completed form to AmeriHealth Caritas Louisiana's Behavioral Health Utilization Management (BHUM) team at **1-855-301-5356**. For assistance, please call **1-855-285-7466**.

Member information	
Patient name:	Legal guardian:
Member date of birth:	Medicaid/health plan #:
Last authorization # (if applicable):	

Provider information	
Provider name:	☐ Participating ☐ Not participating ☐ In credentialing process
Group/agency name: Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LAC ☐ NP ☐ Other, please specify:	
Physical address:	
Phone number:	Fax number:
Medicaid/provider/NPI #:	Contact name:

DSM diagnosis		
Primary Dx:	Secondary Dx:	Medical Dx:
Please also include the ICD-10 diagnosis code along with DSM code. If the member has a substance use and/or HIV diagnosis, has a consent to release information for these related conditions been obtained? ☐ Yes ☐ No ☐ N/A		

Primary care physician (PCP) information and collaboration

Has information been shared with the PCP or other providers regarding:

The initial evaluation and treatment plan? ☐ Yes ☐ No

The updated evaluation and treatment plan? ☐ Yes ☐ No

Other behavioral health provider name and date last notified:

If no, please explain:

	1 None	2 Low	3 Moderate	4 High	5 Extreme
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/violent	☐	☐	☐	☐	☐

Medications

Is member prescribed medications? ☐ Yes ☐ No Prescribing physician(s) name(s):

Is member compliant with medications? ☐ Yes ☐ No

Please list medications and dosages:

Please attach the following to the authorization request: ☐ Clinical assessment ☐ Treatment plan ☐ Choice in provider form

LOCUS: Date of completion:	LMHP name with credentials:

Treatment request (please check services being requested)

☐ **Community psychiatric support and treatment (CPST):** Goal-directed and solution-focused community-based interventions.

Service code: Number of units: per week

☐ **Assertive community treatment (ACT)**

Service code: Number of units: per week

☐ **PSR (psychosocial rehabilitation):** Services to restore a member to the fullest possible extent as an active and productive member of his or her family and community.

PSR individual in the office number of units per week:

PSR individual in the community number of units per week:

PSR group in the office number of units per week:

PSR group in the community number of units per week:

☐ **Crisis intervention follow up:** The member has received emergent crisis intervention services in the initial 24 hour period of the crisis and now requires additional crisis intervention follow up. Services are authorized up to 66 hours per episode and cannot exceed 14 days.

Service code: Number of units: per week

If the requested services are part of permanent supportive housing (PSH): please ensure that the Louisiana Department of Health (LDH) notified AmeriHealth Caritas Louisiana BHUM directly to request an authorization for CPST-PSR with the PSH modifier.

For all initial requests, please indicate below:

1. Treatment plan: please clearly indicate the service (e.g., CPST or PSR) and what interventions (e.g., anger management, social skills, etc.) will be provided under each service requested. Please specify, for each intervention, the duration and frequency of delivery per week (e.g., 30-minute sessions, twice per week) and the number of weeks needed to complete one cycle of intervention (e.g, social skill training lasts 12 weeks, relaxation training and practice sessions lasts eight weeks, etc.).

Problem/goal	**Mental health rehabilitation service**	**Type of intervention**	**Duration** (minutes) **and frequency** (sessions per week)	**Length of intervention** (weeks needed to complete one cycle)	**Who will provide the intervention?**

1a. If you are requesting to provide both CPST and PSR, please explain the need for both services and how the services will differ in content:

1b. If the member has not had any prior behavioral health services, please provide reasons why clinic-based services are not an option:

2. The member is unable to be managed at a less intensive level of care safely within the last week. ☐ Yes ☐ No

3. Is the member currently in short-term respite or any other mental health/substance use disorder service(s)?

☐ Yes ☐ No If yes, explain:

4. The member has displayed any of the following within the last week:

☐ Substance use disorder

☐ Lacks motivation for substance use disorder treatment

☐ Non-suicidal self-injury

☐ Obsessions or compulsions

☐ Inability to utilize or the absence of formal or informal supports (health care providers, family, friends, etc.)

☐ Repeated failure to follow through with acute psychiatric discharge plans

☐ Suicidal ideations

☐ Difficulty with activities of daily living such as cooking, cleaning, financial management, shopping, attending appointments, etc., due to mental illness or substance use disorder

☐ Delusions/ hallucinations

☐ Disorganized thoughts, speech, or behavior

☐ Hypomanic or hypermanic symptoms increased and/or psychomotor agitation

☐ Repeated acute psychiatric hospitalizations

☐ Psychiatric medication noncompliance

5. Have the behaviors been persistent for at least six months? ☐ Yes ☐ No

6. Are the behaviors expected to continue longer than one year without treatment? ☐ Yes ☐ No

7. The member has had unsuccessful treatment history (lack of improvement) in any of the following within the last month (check all that apply):

- ☐ Group home
- ☐ Mental health rehabilitation services (CPST, PSR, ACT)
- ☐ Outpatient therapy services
- ☐ Psychiatric inpatient admission(s)
- ☐ Residential treatment
- ☐ Substance use disorder treatment
- ☐ Therapeutic group home

8. The member's support system is any of the following within the last month (check all that apply):

- ☐ Abusive
- ☐ Intentionally sabotages treatments
- ☐ Involved in treatment and treatment planning
- ☐ Unable to ensure safety
- ☐ Unable to manage the intensity of the member's symptoms without a structured program
- ☐ High risk environment (please specify what makes it high risk):

For all continued stay requests, please indicate the below:

1. Within the last month the member has experienced and/or displayed the following (check all that apply):

- ☐ Depressed mood with associated symptoms
- ☐ Disruptive behaviors (check all that apply):
  - ☐ Has been arrested or negative contact with law enforcement
  - ☐ Physical altercations
  - ☐ Destruction of property
  - ☐ Stalking
  - ☐ Theft
- ☐ Paranoia
- ☐ Post-traumatic stress disorder or history of trauma
- ☐ Hypomanic symptoms
- ☐ Obsessions/compulsions
- ☐ Psychosis
- ☐ Suicidal and/or homicidal ideations (with or without intent)
- ☐ Psychiatric medication noncompliance
- ☐ Has ongoing isolation and/or inappropriate social behaviors
- ☐ Has interpersonal conflicts (check all that apply):
  - ☐ Anger outburst
  - ☐ Poor boundaries
  - ☐ Manipulative
  - ☐ Hostile/intimidating
- ☐ Has been arrested
- ☐ Job or daily structured activities interrupted
- ☐ Is neglecting ADLs and/or needs monitoring for ADLs
- ☐ Has had an after-hour crisis
- ☐ Substance use disorder history with high risk for relapse
- ☐ Non-suicidal self-injury

2. The member is receiving the following services:

Treatment plan: please clearly indicate the service (e.g., CPST or PSR) and what interventions (e.g., anger management, social skills, etc.) will be provided under each service requested. Please specify, for each intervention, the duration and frequency of delivery per week (e.g., 30-minute sessions, twice per week) and the number of weeks needed to complete one cycle of intervention (e.g, social skill training lasts 12 weeks, relaxation training and practice sessions lasts eight weeks, etc.).

Problem/goal	**Mental health rehabilitation service**	**Type of intervention**	**Duration** (minutes) **and frequency** (sessions per week)	**Length of intervention** (weeks needed to complete one cycle)	**Who will provide the intervention?**

2a. If you are requesting to provide both CPST and PSR please explain the need for both services and how the services will differ in content:

2b. Provide reasons why clinic-based services are not an option for this member at this time:

3. Additional clinical information to support the medical necessity of the requested services: