Behavioral Health and Substance Use Disorder
Utilization Management Guide
For Providers

CARE IS THE HEART
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Covered services and prior authorization requirements

**Covered services that do not require prior authorization for in-network providers**: All services requested by an out-of-network provider require prior authorization.

- Outpatient therapy (individual, family and group therapy).
- Assessment and evaluation services.
- Evaluation and management services (E/M codes), medication management, consultations and injection services.
- Emergency department visits.
- Medical team conferences.
- Alcohol and/or substance use disorder (SUD) screening, assessment and/or brief intervention services.
- Alcohol and/or SUD outpatient therapy services (individual, family and group therapy).

**Covered services that do not require prior authorization for in-network providers but require notification for auto-approval**:

- Alcohol and/or SUD acute or subacute detox services.
- Crisis intervention services (initial).

**Covered services that do require prior authorization**:

- Medical psychoanalysis.
- Electroconvulsive therapy (ECT).
- Psychological, neuropsychological or developmental testing (including assessment of aphasia, neurobehavioral status exam).
- Addiction services:
  - SUD intensive outpatient program (IOP)
    - American Society of Addiction Medicine (ASAM) level 2.1.
  - SUD residential services:
    - ASAM level 3.1 — Halfway house.
    - ASAM level 3.3 — Clinically managed low-intensity residential care.
    - ASAM level 3.5 — Clinically managed high-intensity residential care.
- Mental health rehabilitation services (MHRS):
  - Child and adolescent services:
    - Community psychiatric supportive treatment (CPST).
    - Psychosocial rehabilitation services (PSR).
    - Multi-system therapy (MST).
    - Crisis stabilization.
    - Home builders (HB).
    - Functional family therapy (FFT).
    - Therapeutic group home (TGH).
    - Crisis intervention follow up.
  - Adult services:
    - CPST.
    - PSR.
    - Assertive community treatment (ACT) ages 18 and older.
    - Crisis intervention follow up.
- Inpatient/residential levels of care:
  - Psychiatric inpatient hospitalization.
  - Psychiatric residential treatment facility (PRTF).
AmeriHealth Caritas Louisiana does not require prior authorization for SUD detox or initial crisis intervention services.

AmeriHealth Caritas Louisiana does require these services be authorized after completion so ACLA can reach out to members and providers for additional supports, as needed.

Providers must notify the AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (BH UM) department of a member’s SUD detox service and/or a crisis intervention through the following methods, as appropriate:

- Providers should use the Provider Portal to notify AmeriHealth Caritas Louisiana BH UM of the member’s service. If the provider portal is unavailable, providers can call BH UM for telephonic notification.
- Providers must submit clinical information on the member to obtain an authorization number to submit claims for services rendered.
- SUD detox requires a notification and discharge plan. This will assist each member and provider in receiving additional supports.
- Initial crisis intervention requires notification and clinical information. This will assist each member and provider in receiving additional supports.
- After providers use the Provider Portal to notify AmeriHealth Caritas Louisiana of these services, they will obtain an auto-authorization and generated authorization number.
How to request a prior or continued stay authorization

AmeriHealth Caritas Louisiana BH and substance use (SU) providers can request authorizations based on the following:

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Review can be completed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH outpatient services</td>
<td>Faxed form BH outpatient treatment request (OTR) or Provider Portal only</td>
</tr>
<tr>
<td>BH psychological and neuropsychological testing</td>
<td>Faxed form (BH psychological/neuropsychological testing form) or Provider Portal only</td>
</tr>
<tr>
<td>Child and adolescent MHRS</td>
<td>Faxed form (child and adolescent MHRS Form) or Provider Portal only</td>
</tr>
<tr>
<td>Adult MHRS</td>
<td>Faxed form (adult MHRS Form) or Provider Portal only</td>
</tr>
<tr>
<td>Crisis intervention follow up</td>
<td>Faxed form (BH OTR), Provider Portal or telephonic review</td>
</tr>
<tr>
<td>ECT</td>
<td>Telephonic review only</td>
</tr>
<tr>
<td>SUD IOP</td>
<td>Faxed form (MH Inpatient (IP)-SUD Treatment Form) or Provider Portal only</td>
</tr>
<tr>
<td>SUD residential or halfway house services</td>
<td>Faxed form (MH IP-SUD Treatment Form), Provider Portal or telephonic review</td>
</tr>
<tr>
<td>Psychiatric inpatient hospitalization</td>
<td>Faxed form (MH IP-SUD Treatment Form), Provider Portal or telephonic review</td>
</tr>
<tr>
<td>PRTF</td>
<td>Faxed form (PRTF Request Form) only for all initial requests and telephonic review for continued stay requests</td>
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</table>
**Expected turnaround times for treatment requests**

Authorization start dates occur on the date AmeriHealth Caritas Louisiana BH UM receives the request. Providers are asked to submit all requests for services that require authorization before services are rendered or at least by the next business day after rendering services.

Prior authorization for all acute psychiatric inpatient hospitalizations or SUD residential placements is available by telephonic review 24 hours a day, seven days a week, 365 days a year.

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Review completed by</th>
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<tbody>
<tr>
<td>BH outpatient services</td>
<td>Two business days from date all clinical received</td>
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<tr>
<td>BH psychological and neuropsychological testing</td>
<td>Two business days from date all clinical received</td>
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<tr>
<td>Child and adolescent MHRS</td>
<td>Two business days from date all clinical received</td>
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<tr>
<td>Adult MHRS</td>
<td>Five business days from date all clinical received</td>
</tr>
<tr>
<td>ECT</td>
<td>Two business days from date all clinical received</td>
</tr>
<tr>
<td>SUD IOP</td>
<td>Two business days from date all clinical received</td>
</tr>
<tr>
<td>SUD residential or halfway house services</td>
<td>24 hours from date all clinical received</td>
</tr>
<tr>
<td>Psychiatric inpatient hospitalization</td>
<td>24 hours from date all clinical received</td>
</tr>
<tr>
<td>PRTF</td>
<td>48 hours from date certificate of need (CON) received</td>
</tr>
</tbody>
</table>
Frequently asked questions and troubleshooting

1. My authorization dates do not match what I requested.
   a. Check to ensure you are not requesting backdating of services.
   b. Contact the BH UM department for further clarification. BH UM will authorize length of services based on medical necessity per individual member.

2. I received a denial for services based on medical necessity. What should I do?
   a. Refer to the AmeriHealth Caritas Louisiana Provider Manual on how to file an appeal.
   b. Ensure that you have, if applicable and you desire to do so, requested a peer-to-peer review with the psychologist and/or primary care physician that issued the denial for services.

3. I received an administrative denial notification that the services I requested are not a covered benefit for the member. What should I do?
   a. Check the Provider Manual for information on covered benefits.
      i. Some services will not be managed by AmeriHealth Caritas Louisiana but are still available to the member, managed by Magellan.
   b. Contact your account executive for additional questions.

4. I received an administrative denial notification that the member is no longer eligible for AmeriHealth Caritas Louisiana. What should I do?
   a. Check with Louisiana Medicaid for guidance on the member’s current eligibility.

5. I received notification that AmeriHealth Caritas Louisiana BH UM could not verify the member’s identity and could not process my treatment request. What should I do?
   a. Resubmit all documentation initially submitted.
   b. AmeriHealth Caritas Louisiana requires proof of at least two of the following forms of identification to verify a member’s identity:
      i. Member name and date of birth.
      ii. Medicaid ID number.
      iii. AmeriHealth Caritas Louisiana ID number.
      iv. Social Security number.
Requests for BH OPT services requiring prior authorization must be submitted by fax on the Behavioral Health Outpatient Treatment Request (BH OTR) Form. This form is available online at www.amerihealthcaritasla.com.

The BH OTR can be used to submit a written request for crisis intervention follow-up services if you do not submit that request telephonically or through the provider portal.

Below are instructions for completing the BH OTR:

**Member information:** Please complete all requested information for BH UM to verify the member’s identity and eligibility with AmeriHealth Caritas Louisiana.

**Provider information:** Please complete all requested information for BH UM to ensure authorization is provided to the correct participating provider.

**Previous or current BH/SUD treatment:** Please indicate if the member has any of the below:

- None — No previous or current treatment.
- OPT — MH/SUD outpatient therapy.
- SUD IOP.
- MH/SUD IP — Acute psychiatric inpatient hospitalizations.
- MH/SUD residential — Long- or short-term residential program.
- PSR.
- CPST — Any level of care within MHRS.
- Respite care.
- Therapeutic group home.
- Other.

Include specifics on previous and/or current BH/SUD treatment for the member.

**SUD:** Indicate if the member has a history of or current SUD.

**Tobacco use and gaming use:** Indicate if the member has a history of or current tobacco use or gaming issues.

**Indicate the substances used, frequency and member’s last use.**

**Previous or current waiver services:** Indicate “yes” or “no.” If “yes,” provide specifics on past and/or current waiver services.

**Diagnostic and Statistical Manual (DSM) diagnosis:** Include a minimum of primary diagnosis and secondary/medical diagnoses, if applicable.

**If the member has SUD and/or human immunodeficiency virus (HIV), please indicate if the member has signed a consent to release information.**

**Primary care provider (PCP) and other communication:** Use this section to indicate collaboration with PCP and other providers:

- Indicate if initial and updated evaluations and treatment plans have been shared.
- Indicate other providers for the member.
- Indicate the member’s PCP name and last date notified.
- If there has been no collaboration with other providers, please indicate the reason.

**Current risk/lethality:** Use this section to address the member’s safety concerns or issues.

- Suicidal — Current risk rating of 1 – 5.
- Assault/violent — Current risk rating of 1 – 5.

**Medications:** Use this section to indicate if the member is prescribed medications. Provide prescriber, medication information, and compliance to medications.

**Treatment plan and goals:** Use this section to indicate the member’s primary reason for treatment, measureable treatment goals, progress and compliance with treatment plan.

**Treatment request:** Use this section to indicate type of services being requested. All ECT prior authorizations must be completed telephonically.
**Reason for authorization of out-of-network providers:** This section is specific to an out-of-network provider requesting BH OPT services. Out-of-network providers must show medical necessity for the service and a medically necessary reason for BH UM to authorize out-of-network providers.

**Total sessions requested:** Insert number.

**Frequency of visits:** Insert frequency (e.g., weekly, biweekly, monthly).

**Current Procedural Terminology (CPT®) codes.**

**Start date:** Date the authorization is to begin.

**Estimated end date:** Date services are expected to conclude per the member’s treatment plan.

**Provider signature and date.**
Psychological and neuropsychological testing request

AmeriHealth Caritas Louisiana requires prior authorization for all psychological testing and neuropsychological testing.

Requests for psychological or neuropsychological testing must be submitted using the Psychological and Neuropsychological Testing Request Form.

Below are instructions for completing the Psychological and Neuropsychological Testing Request Form:

**Provide all requested member and provider information:** Please provide all required information so BH UM can verify the member’s identity and eligibility. BH UM must also verify the provider’s participating status. Please provide all required information to ensure authorization is provided to the correct participating provider.

**Referral reason/question:** Enter the reason for the referral for psychological or neuropsychological testing or the question to be answered with testing.

**Please explain whether testing is required for educational purposes, behavioral purposes, or both.**

**State how the anticipated results of testing will affect the member’s treatment plan.**

**Indicate the DSM diagnosis:**

- Indicate if the member is a danger to self or others. If “yes”, explain the safety plan.
- Indicate whether the mental status exam (MSE) results are within normal limits. Indicate “yes” or “no”; if “no”, explain the member’s mental status at time of evaluation/request.

**Medications:** Indicate the member’s current psychotropic medications.

**Symptoms:** Check all that apply to the member’s current condition and reason for testing request.

**Indicate if a behavioral health or SUD evaluation has been completed for the member. Attach the most recent evaluation, along with the testing request form.**

**Indicate if the member has had previous testing. If “yes,” indicate the date of last testing, focus or reason, and results of testing.**

**History:** Indicate the member’s last physical examination.

**If the testing request is for ruling out attention deficit hyperactivity disorder (ADHD), a standardized ADHD screening is expected. Please indicate results.**

**Add any additional comments or explanations.**

**Treatment request:** Insert the start date of testing, end date of testing, CPT codes, modifiers and units being requested.

**Tests to be performed:** The full name of the test, reason for performing the test, number of hours requested to perform each test and the standard number of hours required for each test must be included with the request. Without this information, BH UM cannot make a determination of medical necessity for requested testing services.

**Provider signature and date.**
AmeriHealth Caritas Louisiana requires prior authorization for all MHRS provided to children and adolescents.

Criteria that should be included when requesting Child and Adolescent MHRS:

- An assessment and treatment plan.
- The completed Child and Adolescent MHRS Treatment Request Form.

These should include the following information:

- The member’s severity of need for the services. Provide reasoning for the member receiving these services and not treatment in behavioral health outpatient therapy or a level of care higher than MHRS?
- Whether the member had any other treatment services prior to this request. These services can include, but are not limited to, behavioral health outpatient services, inpatient services, prior MHRS, PRTF and psychological testing.
- If the member has not had behavioral health outpatient services before, indicate whether this is available to them in their community.
- If the request is for CPST and PSR, provide information on why these two services are needed instead of just CPST or just PSR?

Below are instructions for completing the Child and Adolescent MHRS Treatment Request Form:

**Member information**: Provide all requested member information so BH UM can verify the member’s identity and eligibility.

- Indicate whether the member has prior authorization and the authorization number if applicable.
- Check “yes” or “no” if the member is current in Louisiana’s Coordinated System of Care (CSoC).

**Provider information**: Please complete all requested information for BH UM to ensure authorization is provided to the correct participating provider. Include the contact information of someone BH UM may contact with questions regarding the treatment request.

**DSM diagnosis**: Include a minimum of primary diagnosis and secondary/medical diagnoses, if applicable.

- If the member has SUD and/or HIV, please indicate if the member has signed a consent to release information.

**PCP and collaboration**: Use this section to indicate collaboration with PCP and other providers:

- Indicate if initial and updated evaluations and treatment plans have been shared.
- Indicate member’s other providers.
- Indicate the member’s PCP name and last date notified.
- If there has been no collaboration with other providers, please indicate the reason.

**Symptoms**: Current risk/lethality — Use this section to address the member’s safety concerns or issues:

- Suicidal — Current risk rating of 1 – 5.
- Assault/Violent — Current risk rating of 1 – 5.
- Medications — Use this section to indicate the member’s prescribed medications. Provide prescriber, medication information and information on the member’s compliance with medications.

**Treatment request**: Use this section to indicate all services being requested and the frequency being requested for each service.

**Initial requests only**: Complete this section when the provider requests that the member receive these services for the first time (i.e., the member does not have a current active authorization for these services). Questions:

- On the form, indicate whether the member has been safely managed at a less intensive level of care within the last week. This would be a less intensive level of care than MHRS.
- On the form, indicate whether the member is enrolled in short-term respite or any other MH or SUD services and explain.
• On the form, please check all that apply based on the member’s current issues within the last week.
  - Fire setting.
  - **Self-injurious behaviors**: Intentional harming of self (cutting, head banging, etc.).
  - **Running away for more than 24 hours**.
  - **Daredevil or impulsive behaviors**: Risk-taking or sensation seeking (substance use experimentation, dangerous activities, etc.).
  - **Sexually inappropriate/aggressive/abusive**.
  - **Encorpresis and feces smearing**.
  - **Angry outbursts/unmanageable aggression**: Examples include but are not limited to: punching, hitting, property destruction, tantrums, throwing or smashing things, biting, kicking, bullying, cruelty to animals.
  - **Delusions/hallucinations/disorganized thoughts, speech or behavior (typically due to psychosis)**.
  - **Arrest/confirmed illegal activity**: Examples include but are not limited to: trespassing, vandalism, theft, having weapons, assaults.
  - **Persistent violation of court orders**: Examples include but are not limited to: probation violation, not follow curfew, running away from foster care placements.

• On the form, indicate whether the member’s behaviors have persisted for at least six months.

• On the form, indicate whether the behaviors are expected to continue without these treatment services.

• On the form, please check all that apply based on the member’s history of unsuccessful treatment attempts member within the last 6 to 12 months.
  - Outpatient therapy services,
  - Mental health rehabilitation services.
  - Treatment foster care.
  - CPST.
  - Residential treatment and/or therapeutic group home.
  - Psychiatric inpatient admissions.
  - Psychiatric partial hospitalizations.
  - Intensive outpatient programs.

• On the form, please check all that apply based on the members support system within the last 6 to 12 months.
  - **Involved in treatment and treatment planning**.
  - **Unavailable**: Formal or informal supports for the member do not exist either due to illness, incarceration, or termination of parental rights.
  - **Unable to ensure safety**.
  - **High-risk environment**: Member lives in an environment that is at a higher risk to their health/wellbeing due to substance use disorder, high violence or crime, mental illness.
  - **Abusive**: Examples can include but are not limited to the member is the victim of abuse or witnesses abuse.
  - **Intentionally sabotaging treatments**: Examples can include but are not limited to the member’s caregivers will not take member to scheduled appointments, will not have medications filled as prescribed, will not ensure member takes medications as prescribed, will not follow medical advice.
  - **Unable to manage the intensity of the member’s symptoms without a structured program**.
Child and adolescent MHRS (continued)

- On the form, please check one that applies to the member’s current living environment.
  - **Member is living in a safe environment:** Member’s environment providers physical, emotional and psychological living conditions to manage the member and their symptoms.
  - **Member is emancipated from family and lacks independent living skills.**
  - **Member has demonstrated intolerance for family environment or adult authority and could need out of home placement.**

- On the form, please check all that apply for the member’s impairments (these should also be outlined or indicated in the member’s assessment).
  - **Activities of daily living (ADL):** The member is unable to care for self or perform basic activities such as feeding, dress, hygiene and SHOULD be able to do these things for themselves based on their developmental age/stage.
  - **Community living:** The member does not display appropriate self control over their behaviors or decisions that has resulted in juvenile justice or could result in juvenile justice involvement.
  - **Social relationships:** Member has continued and consistent problems with keeping positive relationships with adults.
  - **Family relationships:** Member often has unprovoked violence or aggression towards siblings, family or supports that endangers the safety of others.
  - **School performance:** Member has failing grades, truancy, suspensions, expulsions, violence/aggression at school.

**Continued stay requests only:** Complete this section when the provider requests that the member receive a continuation of current services (i.e., the member has a current active authorization for these services).

You can also submit additional clinical documentation if necessary with continued stay requests.

- On the form, please check all that apply based on the member’s current issues within the **last month.**
  - Anxiety and/or depressed mood with associated symptoms.
  - Disruptive behaviors.
  - Post traumatic stress disorder or history of trauma.
  - Hypomanic symptoms.
  - Obsessions/compulsions.
  - Psychosis.
  - Suicidal and/or homicidal ideations without intent.
  - Psychiatric medical noncompliance.
  - Ongoing isolation and/or inappropriate social behaviors.
  - Interpersonal conflicts such as angry outbursts, physical altercations, hostility or intimidation to support system, manipulation, and/or poor boundaries.
  - School problems that could result in suspension or expulsion.
  - Arrest.
  - Neglecting ADLs and/or needs monitoring of ADLs.
  - An after-hours crisis.
• On the form please check all that apply for the member's current interventions:
  
  – **School/vocational programs**: If this applies to the member, include pertinent information such as current information on each program and reason for participation.
  
  – **Self-management/interpersonal skills training**: If this applies to the member, document the frequency of these interventions and any relevant information.
  
  – **Behavior contract or symptoms management plan**: Include relevant clinical information regarding the member's progress and change in plan.
  
  – **Psychoeducation**: Specify if the member has received or is receiving psychoeducation, including topics covered and frequency.
  
  – **Individualized treatment plan**: Include information regarding the member's treatment plan, goals and progress; you may also attach the member's treatment plan in lieu of completing this section.
  
  – **Family, individual, group therapy**: Include information regarding the member's participation and progress in therapy sessions.
  
  – **Other**: Include any other interventions or relevant clinical information.

• Include clinical information to indicate member meets medical necessity for the requested services.
Adult mental health rehabilitation services (MHRS)

AmeriHealth Caritas Louisiana requires prior authorization for all MHRS provided to adults. Adults must meet eligibility for the Adult MHRS State Plan before services can be rendered or authorized. All adult MHRS are authorized based on the member's assessment and Level of Care Utilization System (LOCUS) score.

Requests for adult MHRS must be submitted using the AmeriHealth Caritas Louisiana Adult Mental Health Rehabilitation Treatment Request Form.

Below are instructions for completing the Adult MHRS Treatment Request Form:

**Member information:** Please provide all required information so BH UM can verify the member's identity and eligibility.

- Indicate whether the member has prior authorization and the authorization number if applicable.
- Check “yes” or “no” if the member is current in CSoC.

**Provider information:** Please complete all requested information for BH UM to ensure authorization is provided to the correct participating provider. Include the contact information of someone BH UM may contact with questions regarding the treatment request.

**DSM diagnosis:** Include a minimum of primary diagnosis and secondary/medical diagnoses, if applicable.

- If the member has SUD and/or HIV, please indicate if the member has signed a consent to release information.

**PCP and collaboration:** Use this section to indicate collaboration with PCP and other providers:

- Indicate if initial and updated evaluations and treatment plans have been shared.
- Indicate member's other providers.
- Indicate the member's PCP name and last date notified.
- If there has been no collaboration with other providers, please indicate the reason.

**Symptoms:**

- **Current risk/lethality:** Use this section to address the member's safety concerns or issues:
  - Suicidal — Current risk rating of 1 – 5.
  - Assault/violent — Current risk rating of 1 – 5.
  - Medications — Use this section to indicate the member's prescribed medications. Provide prescriber, medication information and information on the member's compliance with medications.

**Treatment request:** Use this section to indicate all services being requested and the frequency being requested for each service.

**Indicate “yes” or “no” if the Mental Health Assessment has been completed and include the completion date.**

For all requests, please indicate that all items required for authorization are included with the request:

- MHRS assessment.
- Treatment plan (not required but encouraged).
- LOCUS (indicating a score of Level of Care 2 or higher).

Please note that if the member has not received an assessment recommending adult MHRS or does not have a LOCUS score of 2 or higher, the member is not eligible for adult MHRS.
Addiction services and inpatient psychiatric services

AmeriHealth Caritas Louisiana requires prior authorization for certain addiction services. Addiction services that require a prior authorization include SUD rehabilitation programs, SUD halfway house services and SUD IOP.

All inpatient psychiatric hospitalizations require prior authorization.

Requests for inpatient psychiatric hospitalizations and addiction services that require prior authorization can be submitted using the AmeriHealth Caritas Louisiana Behavioral Health Clinical Fax Form.

Below are instructions for completing the Behavioral Health Clinical Fax Form:

**Type of review**: Indicate the type of review being requested: a precertification (the member is not currently being treated at the level of care being requested) or a continued stay (the member is currently being treated at the level of care being requested, with an active authorization).

**Type of admission**: Check the service the member is receiving or requesting and insert an associated HCPCS code, if applicable.

**Admission status**: Indicate whether the member is admitted to the program voluntarily or involuntarily.

**Estimated length of stay**: Insert the number of days or units being requested.

**Indicate whether member had a readmission within 30 days.**

**Member information**: Please provide all required information so BH UM can verify the member’s identity and eligibility.

**Provider information**: Please complete all requested information for BH UM to ensure authorization is provided to the correct participating provider.

- **DSM diagnosis**: Include a minimum of primary diagnosis and secondary/medical diagnoses, if applicable.

**Certificate of Need (CON)**: For members age 21 and under, please indicate if a CON has been completed. If a CON has not been completed, please explain why. Also note that a CON is required for all authorizations for members age 21 and under by close of business the same day the request is submitted.

**Medications**: Include all information related to the member’s medications. Changes to medications are significant in determining medical necessity.

**Presenting problem/current clinical updates**: Use this section to indicate all presenting problems for treatment. Indicate current clinical symptoms including, but not limited to, the member’s behaviors; suicidal or homicidal issues; SUD; and mental status including activities of daily living, mood, affect, appetite and interaction with peers. Please ensure all relevant clinical information is documented regarding the member’s reason for service.

**Treatment history and current treatment participation**: Indicate whether the member has had previous MH or SU inpatient, rehabilitation or detox services. Include information on the member’s outpatient treatment history. If the member is currently undergoing these services, indicate whether the member is attending group therapy and explain the member’s clinical treatment plan for services. Family involvement or support system information is required.

**SUD**: Indicate whether the member does or does not have SUD. If the member has SU issues and the requested service is only for MH, documentation is required on how substance use will be treated while the member is receiving mental health-only services.

If the services requested are addiction services, all information on the current ASAM dimensions is mandatory. AmeriHealth Caritas Louisiana BH UM authorizes addiction services based on ASAM medical necessity.
Addiction services and inpatient psychiatric services (continued)

**Dimension 1 — Acute intoxication and/or withdrawal potential:** insert a rating of 1 – 4 based on the member’s symptoms.

- Information is required on substance use history, toxicology screen results, history of withdrawal symptoms and current withdrawal symptoms.

**Dimension 2 — Biomedical conditions and complications:** insert a rating of 1 – 4 based on the member’s symptoms.

- Information is required on the member’s vital signs, whether the member has current medical conditions or is under a doctor’s care, and the member’s medical history of seizures if applicable.

**Dimension 3 — Emotional, behavioral or cognitive conditions and complications:** insert a rating of 1 – 4 based on the member’s symptoms.

- Information is required on the member’s mental health diagnoses, cognitive limitations if applicable, psychiatric medications, and current psychiatric symptoms and risk factors.

**Dimension 4 — Readiness to change:** insert a rating of 1 – 4 based on the member’s symptoms.

- Information is required on the member’s awareness of and commitment to change, internal and external motivations, stage of change, and any legal problems.

**Dimension 5 — Relapse, continued use or continued problem potential:** insert a rating of 1 – 4 based on the member’s symptoms.

- Information is required on the member’s relapse prevention skills, relapse risk level and longest period of sobriety.

**Dimension 6 — Recovery/living environment:** insert a rating of 1 – 4 based on the member’s symptoms.

- Information is required on the member’s living situation, sober support symptoms, attendance to support groups and issues that might impede the member’s recovery.

**Discharge planning:** This section is required for each member on every review (initial and continued stay). AmeriHealth Caritas Louisiana encourages discharge planning from date of admission. Please include the following:

- Discharge planner name and contact number for AmeriHealth Caritas Louisiana to reach out and assist with discharge planning.
- Residence and treatment setting and provider upon discharge.
- AmeriHealth Caritas Louisiana requires members to have a discharge follow-up session with a licensed mental health professional within seven calendar days of the member’s discharge.

**Collaboration needs:** AmeriHealth Caritas Louisiana needs specific information on the member’s collaboration needs if the member is involved with juvenile justice, child protective agency, school system, nursing home facility, other residential programs, jail, prisons or the court system and others not listed.
Psychiatric rehabilitation treatment facility (PRTF)

AmeriHealth Caritas Louisiana requires prior authorization for all PRTF admissions and continued stays.

The AmeriHealth Caritas Louisiana PRTF Referral Form is required to initiate a request for services, or the member’s full assessment can be substituted for the clinical information requested.

A PRTF Referral Form can be completed by the admitting facility, current treatment provider or referral source. If you have any questions regarding placing a member in a PRTF, please contact BH UM at 1-855-285-7466 and ask to speak to a licensed clinician regarding PRTF placements.

Prior to a PRTF admission, the following must occur:

1. Member is referred to the service and the request is received by the BH UM department.

2. BH UM will coordinate if the member has had a face-to-face assessment completed by a licensed mental health provider (LMHP) who resides in the member’s parish or adjacent parish prior to the referral for PRTF.
   a. If an LMHP has completed a face-to-face assessment with the member and recommends the member be placed in a PRTF, the BH UM department will schedule a teleconference with the LMHP. Members of this conference will include:
      i. BH medical director or designee.
      ii. BH UM supervisor.
      iii. BH UM clinical staff.
      iv. If the member is in state custody, the legal guardian of the state.
   b. If an LMHP has not completed a face-to-face assessment with the member, BH UM will facilitate an LMHP in the member’s parish or an adjacent parish to complete a face-to-face assessment with the member within 14 calendar days of the request or referral for PRTF. Once the face-to-face assessment is completed and returned to the BH UM department, the BH UM department will schedule a teleconference with the LMHP. Members of this conference will include:
      i. BH medical director or designee.
      ii. BH UM supervisor.
      iii. BH UM clinical staff.
      iv. If the member is in state custody, the legal guardian of the state.
      v. Any other support or service providers familiar with the member’s care and ambulatory resources available to the member.

3. The PRTF meeting is required for AmeriHealth Caritas Louisiana to complete the member’s CON for services.

4. Once the CON is complete, BH UM will make a medical necessity determination within 48 hours.

Continued stay requests for PRTF must be submitted by the PRTF provider via a telephonic clinical review with BH UM. Continued stay requests are due on the last covered day of the PRTF authorization.
Appendix

Samples of treatment request forms

1. Behavioral Health Outpatient Treatment Request Form

2. Behavioral Health Psychological and Neuropsychological Testing Request Form

3. Mental Health Rehabilitation Treatment Request Form
   a. Child and Adolescent Mental Health Rehabilitation Treatment Request Form
   b. Adult Mental Health Rehabilitation Treatment Request Form

4. Addiction and Psychiatric Inpatient Services Form (Behavioral Health Clinical Fax Form)
## Behavioral Health Outpatient Treatment Request Form

Please print clearly — incomplete or illegible forms will delay processing. Please fax to: AmeriHealth Caritas Louisiana BH UM at **1-855-301-5356**. For assistance contact: **1-855-285-7466**.

### Member information

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Louisiana</td>
<td>1.1.2000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid/health plan number:</th>
<th>Last authorization number (if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Provider information

<table>
<thead>
<tr>
<th>Provider name:</th>
<th>Provider credential:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Rouge</td>
<td>MD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group/agency name:</th>
<th>Telephone number:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Health</td>
<td>789.456.1236</td>
<td>789.456.1234</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid/Provider/NPI #:</th>
<th>Contact name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>Patty Date</td>
</tr>
</tbody>
</table>

### Previous or current BH/SA treatment:

- ☐ None or ☐ OPT: MH/SA ☐ SA IOP ☐ MH/SA Residential ☐ PSR
- ☐ CPST: (ACT, MST, FFS, CPST, HB) ☐ Respite care ☐ Therapeutic group home (TGH) ☐ Other

**Provide specifics:** Patient has not had any prior treatment

### Substance abuse:

- ☐ None
- ☐ By history or ☐ Current/active

### Tobacco abuse:

- ☐ None
- ☐ By history or ☐ Current/active

### Gaming abuse:

- ☐ None
- ☐ By history or ☐ Current/active

**Substance(s) used, amount, frequency and last used:** NA

**Previous or current waiver services:** ☐ Yes ☐ No

**If yes, give specifics:** NA

**DSM diagnosis:**

- Primary DX: F41.9 (300) ☐ Secondary DX: None ☐ Medical DX: None

**If the member has a substance abuse and/or HIV diagnosis, has a consent to release information for these related conditions been obtained?**

- ☐ Yes ☐ No ☐ N/A

Page 1 of 3
**Behavioral Health Outpatient Treatment Request Form**

Primary medical physician (PMP) and other communication: Has information been shared, to the extent permissible, with the PMP/other providers regarding:

1. The initial evaluation and treatment plan?  □ Yes  □ No
2. The updated evaluation and treatment plan?  □ Yes  □ No

Other behavioral health providers names and last notified:  none

PMP name and date last notified:  Dr. Jon Smith 2.1.2016

If no, please explain:  NA

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicidal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault/violent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications: Is the member prescribed medications?</th>
<th>Is the member compliant with medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

Prescribing physician(s) name(s):  NA

Please list medications and dosages:  NA

<table>
<thead>
<tr>
<th>Treatment plan and goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>List primary complaint/problem to be addressed:  Cope with anxiety</td>
</tr>
<tr>
<td>Overall progress toward goals:  □ 1 None  □ 2 Minimal  □ 3 Moderate  □ 4 Met</td>
</tr>
</tbody>
</table>

| List measurable treatment goals:  Decrease anxiety symptoms by 50% |
| Compliance with treatment:  □ 1 None  □ 2 Minimal  □ 3 Moderate  □ 4 Met |

<table>
<thead>
<tr>
<th>Treatment request</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Individual  □ Group  □ Family  □ Med management  □ ECT (call BH UM for PA)</td>
</tr>
</tbody>
</table>

Reason for authorization of non-participating providers

(Utilization Management will contact provider directly before giving an authorization)

Provider is in credentialing process to be in-network

<table>
<thead>
<tr>
<th>Participating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specialty of provider to meet the needs of the member:  NA</td>
</tr>
<tr>
<td>2. Continuity of care concerns:  NA</td>
</tr>
<tr>
<td>3. Accessibility/availability of provider:  NA</td>
</tr>
<tr>
<td>4. Clinical rationale:  NA</td>
</tr>
</tbody>
</table>

Page 2 of 3
## Behavioral Health Outpatient Treatment Request Form

<table>
<thead>
<tr>
<th>Total sessions requested: 24</th>
<th>Start date: 2.2.2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of visits: 1 per week</td>
<td>Estimated end date: 7/19/2016</td>
</tr>
<tr>
<td>CPT codes: 90832</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Signature</th>
<th>2.1.2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
### Behavioral Health Psychological/Neuropsychology Testing Request Form

Please print clearly — incomplete or illegible forms will delay processing.
Submit to: Behavioral health utilization management
Fax: 1-855-301-5356
For assistance please call 1-855-285-7466

<table>
<thead>
<tr>
<th>Member information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient name:</strong></td>
<td>Hart Smith</td>
</tr>
<tr>
<td><strong>Health plan:</strong></td>
<td>AmeriHealth Caritas</td>
</tr>
<tr>
<td><strong>Date of birth:</strong></td>
<td>2.2.2000</td>
</tr>
<tr>
<td><strong>Social security #:</strong></td>
<td>987-65-3214</td>
</tr>
<tr>
<td><strong>Patient ID or MAID ID #:</strong></td>
<td>987654321</td>
</tr>
<tr>
<td><strong>Referral source:</strong></td>
<td>BH Outpatient Therapist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider:</strong></td>
<td>q Provider</td>
</tr>
<tr>
<td><strong>Group/agency:</strong></td>
<td>q Group/agency</td>
</tr>
<tr>
<td><strong>Name:</strong></td>
<td>Dr. Johnson</td>
</tr>
<tr>
<td><strong>Provider credential:</strong></td>
<td>MD, PhD</td>
</tr>
<tr>
<td><strong>Other, please specify:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physical address:</strong></td>
<td>963 Health Way Baton Rouge, LA</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>741.852.9632</td>
</tr>
<tr>
<td><strong>Fax number:</strong></td>
<td>741.852.9631</td>
</tr>
<tr>
<td><strong>Medicaid/TPI/NPI #:</strong></td>
<td>741852963</td>
</tr>
<tr>
<td><strong>Tax ID #:</strong></td>
<td>741852963</td>
</tr>
</tbody>
</table>

### Referral reason/question

Testing will not be authorized under any of the following conditions:
1. Testing is primarily for educational or vocational purposes.
2. Testing is primarily for legal purposes.
3. The tests requested are experimental or have no documented validity.
4. The time requested to administer the testing exceeds established time parameters.
5. Testing is routine for entrance into a treatment program.

Is this testing required for educational purposes, behavioral health purposes, or both?

**Explain:**

Behavioral Health purposes only

State how the anticipated results of the testing will affect the patient’s treatment plan:

Testing will help facilitate improved treatment planning for BH services
Behavioral Health Psychological/Neuropsychology Testing Request Form

### DSM IV Axis

<table>
<thead>
<tr>
<th>Axis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>300.0</td>
<td>R/O</td>
</tr>
<tr>
<td>Axis II</td>
<td>Deferred</td>
<td></td>
</tr>
<tr>
<td>Axis III</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Axis IV</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td>Current</td>
<td>Past year</td>
</tr>
</tbody>
</table>

- Danger to self or others? □ Yes □ No
  - If yes, please explain:

- MSE within normal limits? □ Yes □ No
  - If no, please explain:
    - anxious mood, blunted affect, poor sleeping and poor appetite

### List current medications:

<table>
<thead>
<tr>
<th>Name/strength</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prozac 20 mg</td>
<td>Daily</td>
</tr>
</tbody>
</table>

### What are the current symptoms prompting the request for testing?

- Anxiety
- Depression
- Inattention
- Confusion
- Hypo-activity
- Hyperactivity
- Psychosis/hallucinations
- Bizarre behavior
- Unprovoked agitation/aggression
- Self-injurious behavior eating
- Disorder symptoms
- Withdraw/poor social interaction
- Mood instability
- Changes in memory capacity
- Changes in cognitive capacity
- Behavior problems affecting life functions (e.g., school, home)
- Poor academic performance
- Other, list:

### Comments/explain:
Sample: Behavioral Health Psychological/Neuropsychological Testing Request Form, page 3 of 4

Behavioral Health Psychological/Neuropsychology Testing Request Form

Was a behavioral health/substance abuse evaluation completed?

- Yes  
- No  
  Date: 12/15/2015

Results and attach all relevant clinical information to request:

see attached assessment

Was previous psychological or neuropsychological testing conducted?

- Yes  
- No  
  Date: NA

Basic focus and results:

NA

History

When was the patient’s last physical examination? 12/1/15

If ADHD is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available:

- Positive
- Negative
- Inconclusive
- Not applicable

Comment/explain:

Treatment Request

<table>
<thead>
<tr>
<th>Start date MM/DD/YY</th>
<th>Stop date MM/DD/YY</th>
<th>CPT code</th>
<th>Modifier(s)</th>
<th>Units requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/15/16</td>
<td>5/15/16</td>
<td>96101</td>
<td>NA</td>
<td>5 hours</td>
</tr>
</tbody>
</table>

Page 3 of 4
### Behavioral Health Psychological/Neuropsychology Testing Request Form

#### Please list the tests planned to answer the clinical questions:

<table>
<thead>
<tr>
<th>Test</th>
<th>Reason for use</th>
<th>Educational Yes/No</th>
<th>Number of units requested for test</th>
<th>Number of units approved for test</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFAST</td>
<td>screening interview</td>
<td>No</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>KBIT-2</td>
<td>intelligence</td>
<td>No</td>
<td>3 hours</td>
<td></td>
</tr>
<tr>
<td>Thomatic Test</td>
<td>personality</td>
<td>No</td>
<td>1 hour</td>
<td></td>
</tr>
</tbody>
</table>

Indicate the total number of units (hours) requested: 5 hours

---

Provider Signature: ___________________________  Date: 2/2/16
**Child and Adolescent Mental Health Rehabilitation Treatment Request Form**

Please complete this form in its entirety — incomplete forms will delay processing.
Please return to AmeriHealth Caritas Louisiana BH UM at **1-855-301-5356**.
For assistance, contact **1-855-285-7466**.

### Member information

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Jan Doe</th>
<th>Legal guardian:</th>
<th>Henry Doe</th>
<th>Date of birth:</th>
<th>1.1.2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/health plan #:</td>
<td>123456789</td>
<td>Last authorization # (if applicable):</td>
<td>NA (initial request)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the member currently in coordinated system of care (CSOC)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Provider information

<table>
<thead>
<tr>
<th>Provider name:</th>
<th>Wayward Services</th>
<th>Provider credential:</th>
<th>M.D.</th>
<th>Ph.D.</th>
<th>LMHP</th>
<th>LAC</th>
<th>N.P.</th>
<th>MHRS agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group/agency name:</td>
<td>Same as above</td>
<td>Phone:</td>
<td>888.888.9999</td>
<td>Fax:</td>
<td>888.888.9999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical address:</td>
<td>123 Seaside Dr. Baton Rouge, LA</td>
<td>Medicaid/provider/NPI #:</td>
<td>123456789</td>
<td>Contact name:</td>
<td>Holly Dolly</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DSM diagnosis

<table>
<thead>
<tr>
<th>Primary Dx:</th>
<th>F32</th>
<th>Secondary Dx:</th>
<th>None</th>
<th>Medical Dx:</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the member has a substance use and/or HIV diagnosis, has consent to release information for these related conditions been obtained?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PCP information and collaboration

Has information been shared with the primary care provider (PCP) or other providers regarding:

- The initial evaluation and treatment plan? | Yes | No |
- The updated evaluation and treatment plan? | Yes | No |
- Other behavioral health providers' names and date last notified; PCP name and date last notified: | Susie Brown LPC, Dr. Word (PCP) |

If no, please explain: ____________________________

### Symptoms

<table>
<thead>
<tr>
<th>Suicidal</th>
<th>1 None</th>
<th>2 Low</th>
<th>3 Moderate</th>
<th>4 High</th>
<th>5 Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicidal</td>
<td>1 None</td>
<td>2 Low</td>
<td>3 Moderate</td>
<td>4 High</td>
<td>5 Extreme</td>
</tr>
<tr>
<td>Assault/violent</td>
<td>1 None</td>
<td>2 Low</td>
<td>3 Moderate</td>
<td>4 High</td>
<td>5 Extreme</td>
</tr>
</tbody>
</table>

Is member prescribed medications? | Yes | No |
Prescribing physicians' names: | Dr. Word |

Is the member compliant with medications? | Yes | No |
Please list medications and dosages: | Adderal XR 10mg daily |
# Child and Adolescent Mental Health Rehabilitation Treatment Request Form

Please attach the following to the treatment request:  
- [ ] Clinical assessment  
- [ ] Treatment plan

## Treatment request: please check services being requested

- [ ] Community psychiatric support and treatment (CPST): Goal-directed and solution-focused community-based interventions.
  1. Service code being requested: H0036  
  2. Number of units: 40  
  3. Frequency: monthly

- [ ] Therapeutic group home (TGH): Community-based residential services in a home-like setting.
  1. Service code being requested:  
  2. Number of units:  
  3. Frequency:  

- [ ] Home builders (HB): Provides youth between birth and 18 years old intensive in-home cognitive behavioral therapy through family therapy and parent training. Youth are at risk of out-of-home placement, returning from out-of-home placement, or have serious behavior problems at home and school.
  1. Service code being requested:  
  2. Number of units:  
  3. Frequency:  

- [ ] Multi-systemic therapy (MST): Provides youth between 12 and 17 years old intensive home-, family- and community-based therapy. Youth are at risk of out-of-home placement or are returning from out-of-home placement.
  1. Service code being requested:  
  2. Number of units:  
  3. Frequency:  

- [ ] Family functional therapy (FFT): For youth between 10 and 18 years old, targeting behaviors that impact family functioning.
  1. Service code being requested:  
  2. Number of units:  
  3. Frequency:  

- [ ] Psychosocial rehabilitation (PSR): Services to restore a member to the fullest possible extent as an active and productive member of his or her family and community.
  1. PSR individual in the office, # of units per week: 10  
  2. PSR individual in the community, # of units per week:  
  3. PSR group in the office, # of units per week: 5  
  4. PSR group in the community, # of units per week:  

- [ ] Crisis stabilization: Short-term and intensive supportive resources for youth and family; out-of-home option to avoid psychiatric inpatient or institutional treatment. This service is being requested to prevent the member from inpatient or institutional treatment, and the member is currently in crisis. Up to seven days will be authorized initially, and a child cannot receive more than 30 calendar days of this service per year.
  1. Service code being requested:  
  2. Number of units:  
  3. Frequency:  

---

2 | AmeriHealth Caritas Louisiana Child and Adolescent Mental Health Rehabilitation Treatment Request Form
**Child and Adolescent Mental Health Rehabilitation Treatment Request Form**

**For all initial requests, please indicate the below**

1. The member has been unmanageable safely at a less intensive level of care within the last week.  
   ![ ] Yes  ![ ] No

2. The member is currently in short-term respite or any other mental health or substance use disorder services.  
   ![ ] Yes  ![ ] No
   
   If yes, please explain: Member is currently receiving behavioral health outpatient treatment - she is not in respite.

3. The member has displayed any of the following within the last week (check all that apply):
   - ![ ] Fire setting
   - ![ ] Self-injurious behaviors
   - ![ ] Running away for more than 24 hours
   - ![ ] Daredevil or impulsive behaviors
   - ![ ] Sexually inappropriate/aggressive/abusive
   - ![ ] Encopresis and feces smearing
   - ![ ] Angry outbursts/unmanageable aggression
   - ![ ] Delusions/hallucinations/disorganized thoughts, speech or behavior
   - ![ ] Arrest/confirmed illegal activity
   - ![ ] Persistent violation of court orders

4. The behaviors have persisted for at least six months.  
   ![ ] Yes  ![ ] No

5. The behaviors are expected to continue longer than one year without treatment.  
   ![ ] Yes  ![ ] No

6. The member has had unsuccessful treatment in any of the following within the last 6 – 12 months (check all that apply):
   - ![ ] Outpatient therapy services
   - ![ ] Residential treatment and/or therapeutic group home
   - ![ ] Three psychiatric inpatient admissions
   - ![ ] Three psychiatric partial hospitalization admissions
   - ![ ] Four psychiatric admissions to inpatient, partial hospitalization program (PHP) or intensive outpatient program (IOP) in any combination
   - ![ ] Mental health rehabilitation services
   - ![ ] Treatment foster care
   - ![ ] CPST

7. The member’s support system has been any of the following within the last 6 – 12 months (check all that apply):
   - ![ ] Involved in treatment and treatment planning
   - ![ ] Abusive
   - ![ ] Intentionally sabotaging treatments
   - ![ ] Unable to manage the intensity of the member’s symptoms without a structured program
   - ![ ] Unavailable
   - ![ ] Unable to ensure safety
   - ![ ] High-risk environment

8. The member’s living environment (please check one):
   - ![ ] Member is living in a safe environment
   - ![ ] Member is emancipated from family and lacks independent living skills
   - ![ ] Member has demonstrated intolerance for family environment or adult authority and needs out-of-home placement
Child and Adolescent Mental Health Rehabilitation Treatment Request Form

For all initial requests, please indicate the below (continued)

9. The member has severe impairment in the below (check all that apply):

☐ Activities of daily living (ADLs)
☐ Community living
☐ Social relationships

☐ Family relationships
☐ School performance

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):

☐ Anxiety and/or depressed mood with associated symptoms
☐ Disruptive behaviors
☐ Post-traumatic stress disorder (PTSD) or history of trauma
☐ Hypomanic symptoms
☐ Obsessions/compulsions
☐ Psychosis
☐ Suicidal and/or homicidal ideations without intent
☐ Psychiatric medication noncompliance

☐ Ongoing isolation and/or inappropriate social behaviors
☐ Interpersonal conflicts that can include angry outbursts, physical altercations, hostility or intimidation to support system, manipulation, and/or poor boundaries

☐ School problems resulting in suspensions or expulsion
☐ Arrest
☐ Neglecting ADLs and/or needs monitoring for ADLs

☐ An after-hours crisis

2. The member is receiving the following services:

☐ School and/or vocational program; indicate program information:

☐ Self-management or interpersonal skills training; indicate frequency:

☐ Behavior contract or symptom management plan; indicate frequency:

☐ Psychoeducation; indicate frequency:

☐ Individualized treatment plan; indicate primary goals:

☐ Family, individual, group therapy; indicate frequency:

☐ Other:

3. Additional clinical information to indicate member meets medical necessity for the requested services:
# Adult Mental Health Rehabilitation Treatment Request Form

Please complete this form in its entirety — incomplete forms will delay processing. Please return to AmeriHealth Caritas Louisiana BH UM at **1-855-301-5356**. For assistance contact, **1-855-285-7466**.

## Member information

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Uri Lemon</th>
<th>Legal guardian (if applicable):</th>
<th>NA</th>
<th>Date of birth:</th>
<th>5.5.1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/health plan #:</td>
<td>987654321</td>
<td>Last authorization # (if applicable):</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Provider information

<table>
<thead>
<tr>
<th>Provider name:</th>
<th>Dream Believers</th>
<th>In-network</th>
<th>Yes</th>
<th>Out of network</th>
<th>No</th>
<th>In credentialing process</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group/agency name:</td>
<td>Same as above</td>
<td>Provider credential:</td>
<td>M.D.</td>
<td>Ph.D.</td>
<td>LMHP</td>
<td>LAC</td>
<td>N.P.</td>
</tr>
<tr>
<td>Physical address:</td>
<td>741 Seven Four Dr. New Orleans, L</td>
<td>Phone:</td>
<td>888.333.9874</td>
<td>Fax:</td>
<td>888.333.9875</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid/provider/NPI #:</td>
<td>456123789</td>
<td>Contact name:</td>
<td>Elizabeth Moore</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## DSM diagnosis

<table>
<thead>
<tr>
<th>Primary Dx:</th>
<th>F20.0</th>
<th>Secondary Dx:</th>
<th>None</th>
<th>Medical Dx:</th>
<th>E08</th>
</tr>
</thead>
</table>

If the member has a substance use and/or HIV diagnosis, has consent to release information for these related conditions been obtained?

- [ ] Yes
- [ ] No
- [x] N/A

## PCP information and collaboration

Has information been shared with the primary care provider (PCP) or other providers regarding:

The initial evaluation and treatment plan?  
- [x] Yes
- [ ] No

The updated evaluation and treatment plan?  
- [ ] Yes
- [x] No

Other behavioral health providers' names and date last notified; PCP name and date last notified:  
PCP: Dr. Trott  
If no, please explain:

## Symptoms

<table>
<thead>
<tr>
<th>Suicidal</th>
<th>1 None</th>
<th>2 Low</th>
<th>3 Moderate</th>
<th>4 High</th>
<th>5 Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicidal</td>
<td>1 None</td>
<td>2 Low</td>
<td>3 Moderate</td>
<td>4 High</td>
<td>5 Extreme</td>
</tr>
<tr>
<td>Assault/Violent</td>
<td>1 None</td>
<td>2 Low</td>
<td>3 Moderate</td>
<td>4 High</td>
<td>5 Extreme</td>
</tr>
</tbody>
</table>

Is member prescribed medications?  
- [x] Yes
- [ ] No

Prescribing physicians' names:  
Psychiatrist: Dr. Post

Is the member compliant with medications?  
- [x] Yes
- [ ] No

Please list medications and dosages:  
Zyprexa 10mg bid, Remeron 45mg qhs, Effexor 150mg qam, Buspar 15mg tid
**Adult Mental Health Rehabilitation Treatment Request Form**

**Treatment request: please check services being requested**

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Units</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community psychiatric support and treatment (CPST)</td>
<td>H0036</td>
<td>60</td>
<td>monthly</td>
</tr>
</tbody>
</table>

**Assertive community treatment (ACT)**

1. Service code being requested:  
2. Number of units:  
3. Frequency: 

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

1. PSR individual in the office, # of units per week:  
2. PSR individual in the community, # of units per week:  
3. PSR group in the office, # of units per week:  
4. PSR group in the community, # of units per week: 

Are the requested services part of permanent supportive housing (PSH)?  
Yes  
No

**For all initial requests, please indicate the below**

(Please note that adult mental health rehabilitation services cannot be authorized without the completed assessment and LOCUS).

Has the Adult Mental Health Rehabilitation Assessment been completed?  
Yes  
No (insert date: )

If yes, please attach the following:  
Assessment  
LOCUS  
Treatment plan (we highly encourage sending a treatment plan)

If no, please explain:  

---

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ACLA-1622-06
### Behavioral Health Clinical Fax Form

When complete, please fax to 1-855-301-5356.

#### Today's date: 1.29.2016  
Date of admission/service start: 1.28.2016

<table>
<thead>
<tr>
<th>Type of review:</th>
<th>☑ Precertification</th>
<th>☐ Continued stay</th>
<th>Estimated length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Partial hospitalization program (PHP)/day treatment</td>
<td>☑ Substance use intensive outpatient program (SU IOP)</td>
<td></td>
</tr>
<tr>
<td>Type of admission:</td>
<td>☐ Mental health inpatient (MH-IP)</td>
<td>☘ Substance use rehab</td>
<td>☐ Substance use detox</td>
</tr>
<tr>
<td>Admission status:</td>
<td>☑ Voluntary</td>
<td>☐ Involuntary commitment</td>
<td>Readmission within 30 days?</td>
</tr>
<tr>
<td></td>
<td>☑ Yes</td>
<td>☐ No</td>
<td></td>
</tr>
</tbody>
</table>

#### Member information

<table>
<thead>
<tr>
<th>Last, first, MI:</th>
<th>Caritas, Health</th>
<th>Date of birth:</th>
<th>3.3.1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member's address:</td>
<td>789 Caritas Rd Baton Rouge, LA</td>
<td>Eligibility ID:</td>
<td>987654321</td>
</tr>
<tr>
<td>Emergency contact (other than primary caregiver):</td>
<td>You Caritas</td>
<td>Phone:</td>
<td>321654987</td>
</tr>
<tr>
<td>Legal guardian/parent:</td>
<td>NA</td>
<td>Phone:</td>
<td>NA</td>
</tr>
</tbody>
</table>

#### Provider information

<table>
<thead>
<tr>
<th>Facility/provider name: Road to Recovery</th>
<th>NPI/tax ID: 741852963</th>
<th>Provider ID: 741852</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility/provider address: 123 Recovery Rd. New Orleans, LA</td>
<td>Attending M.D.: Dr. Jon Smith</td>
<td></td>
</tr>
<tr>
<td>Utilization Management review contact: Henry Henrietta</td>
<td>Phone: 963.582.7412</td>
<td></td>
</tr>
</tbody>
</table>

#### DSM-5 diagnoses (include mental health, substance use and medical):

For members age 21 and under: Has a certificate of need (CON) been completed? ☑ Yes ☐ No

If yes, please attach to request. If no, please explain: F10.20 Alcohol Dependence

Please note that all behavioral health inpatient (B1-IP) admissions for members age 21 and under require a CON be submitted to AmeriHealth Caritas Louisiana by close of business on the same day a request is submitted.

### Medications

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Date of last</th>
<th>Type of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prozac</td>
<td>10mg</td>
<td>TID</td>
<td>1.1.2016</td>
<td>☑ Increase ☑ Decrease ☐ D/C ☐ New</td>
</tr>
</tbody>
</table>

Additional information: Pt is non-compliant with psychotropic medications
### Behavioral Health Clinical Fax Form

#### Presenting problem/current clinical update

Suicidal ideation (SI), homicidal ideation (HI), psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SU:

Pt reports feelings of depression, a sense of hopelessness and helpless. He states he has fleeting thoughts about harming himself due to being so depressed. He recently lost his job due to going into work too hung over to perform his responsibilities. He is attending to his basic ADL’s however is not showering as often as he states he normally does. Prior to detox he went on a 4 day drinking binge. His wife has left him due to his continued drinking. Pt has a pending drunk and disorderly charge.

#### Treatment history and current treatment participation

<table>
<thead>
<tr>
<th>Previous MH/SU inpatient, rehab, detox:</th>
<th>Detox in 1999, SA rehab in 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient treatment history:</td>
<td>SUD IOP 1999</td>
</tr>
<tr>
<td>Is the member attending therapy and groups?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Explain clinical treatment plan:</td>
<td>relapse prevention, family, individual group therapy, self-help support</td>
</tr>
<tr>
<td>Family involvement/support system:</td>
<td>wife has agreed to attend family sessions</td>
</tr>
</tbody>
</table>

#### Substance use

Yes  No

If yes and MH services only, please explain how substance use is being treated: NA

Please complete below for current ASAM dimensions and/or submit with documentation for SUD IOP, PHP/day treatment, SUD detox and SU rehab

<table>
<thead>
<tr>
<th>Dimension rating (0 - 4)</th>
<th>Current ASAM dimensions are required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension 1: Acute intoxication and/or withdrawal potential</td>
<td></td>
</tr>
<tr>
<td>Alcohol, oral, 12-24 daily</td>
<td></td>
</tr>
<tr>
<td>Toxicology screening completed?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>If yes, results:</td>
<td>negative</td>
</tr>
<tr>
<td>History of withdrawal symptoms:</td>
<td>poor sleep, vomiting, anxiety, seizures in 1999</td>
</tr>
<tr>
<td>Current withdrawal symptoms:</td>
<td>None, recently released from detox (7 days)</td>
</tr>
<tr>
<td>Rating: 2</td>
<td></td>
</tr>
<tr>
<td>Dimension 2: Biomedical conditions and complications</td>
<td></td>
</tr>
<tr>
<td>Vital signs:</td>
<td>within normal limits</td>
</tr>
<tr>
<td>Is patient under doctor care?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Current medical conditions:</td>
<td>high blood pressure</td>
</tr>
<tr>
<td>History of seizures?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Rating: 1</td>
<td></td>
</tr>
<tr>
<td>Dimension 3: Emotional, behavioral or cognitive conditions and complications</td>
<td></td>
</tr>
<tr>
<td>MH diagnosis:</td>
<td>Depressive Disorder</td>
</tr>
<tr>
<td>Cognitive limits?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Psych medication and dosages:</td>
<td>Prozac but has been non-compliant</td>
</tr>
<tr>
<td>Current risk factors (SI, HI, psychotic symptoms, etc.):</td>
<td>SI with no plan</td>
</tr>
<tr>
<td>Rating: 3</td>
<td></td>
</tr>
</tbody>
</table>

(Continued on next page)
## Behavioral Health Clinical Fax Form

<table>
<thead>
<tr>
<th>Dimension 4: Readiness to change</th>
<th>Awareness/commitment to change: Pt states he is ready</th>
<th>Internal or external motivation: External</th>
<th>Stage of change, if known: unknown</th>
<th>Legal problems/probation officer: pending charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating: 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension 5: Relapse, continued use or continued problem potential</td>
<td>Relapse prevention skills: has been sober before</td>
<td>Current assessed relapse risk level: ☐ Low ☐ Moderate ☐ High</td>
<td>Longest period of sobriety: 2 years</td>
<td></td>
</tr>
<tr>
<td>Rating: 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension 6: Recovery/living environment</td>
<td>Living situation: with wife</td>
<td>Sober support system: wife</td>
<td>Attendance at support group: 2002</td>
<td>Issues that impede recovery: relapse, depression</td>
</tr>
<tr>
<td>Rating: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Discharge planning

Discharge planner name and contact: Caritas Dole @ 888.333.2121

Residence address upon discharge: TBD, pt has expressed interest in SUD halfway house

Treatment setting and provider upon discharge: Halfway House/SUD IOP

Has a post-discharge 7-day follow-up aftercare appointment been scheduled? ☐ Yes ☐ No

If no, please explain: Mbr admitted and will remain in treatment for 30-60 days

If yes, please provide treatment provider name, date and time of scheduled follow-up: BA

### Collaboration needs

Please indicate if collaboration is needed with any of the below, including contact name and phone number.

- Juvenile justice: NA
- Child or adult protective agency: NA
- School system: NA
- Nursing or nursing home facility: nA
- Residential program: NA
- Jail/prison/court system: pending charges but collaboration needed at this time
- Other: NA

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ACLA-1622-11
Acronym Index

Activities of daily living  ADL
American Society of Addiction Medicine  ASAM
Assertive community treatment  ACT
Behavioral health outpatient therapy  BH OPT
Behavioral health outpatient treatment request form  BH OTR
Behavioral Health Utilization Management department  BH UM
Certificate of Need  CON
Community psychiatric supportive treatment  CPST
Diagnostic and Statistical Manual  DSM
Electroconvulsive therapy  ECT
Functional family therapy  FFT
Home builders  HB
Intensive outpatient program  IOP
Mental health rehabilitation services  MHRS
Multi-system therapy  MST
Psychiatric rehabilitation treatment facility  PRTF
Psychosocial rehabilitation services  PSR
Substance use disorder  SUD
Therapeutic group home  TGH
This handbook may be updated with additional text provided by the Department of Health & Hospitals or other information we feel is important for you to know.

Revision date April 2016
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