Behavioral Health and Substance Use Disorder

Utilization Management Guide

For Providers

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AmeriHealth Caritas™
Louisiana

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Table of contents

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).
- 30-hour observations.
- Assessment and evaluation services.
- Evaluation and management services (E/M codes), medication management, consultations and therapeutic 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).
- "In lieu of" services:
  - 23-hour observation bed services for adults age 21 and older.
  - Injection services provided by licensed nurses to adults age 21 and older.
  - Population health management programs.

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 for the first five days (SUD detox services for days six and beyond require a prior authorization and medical necessity review).
- Crisis intervention services (initial).
- Mobile crisis response (MCR) initial contact — first 24 hours (age 21 and older).
- Behavioral health crisis care (BHCC) — initial first 23 hours of a crisis episode (age 21 and older).

Covered services that do require prior authorization:

- Medical psychoanalysis.
- Electroconvulsive therapy (ECT).
- Applied behavior analysis (ABA).
- 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.
    - ASAM level 3.7 — Medically monitored intensive inpatient treatment.
- Mental health rehabilitation services (MHRS):
  - Child and adolescent services:
    - Community psychiatric supportive treatment (CPST).
    - Psychosocial rehabilitation services (PSR).
    - Multisystemic therapy (MST).
    - Crisis stabilization.
    - Home builders (HB).
    - Family functional therapy (FFT) and FFT-Child Welfare.
    - Therapeutic group home (TGH).
    - Crisis intervention follow up.
  - Adult services:
    - CPST.
    - PSR.
    - Assertive community treatment (ACT) ages 18 and older.
    - Crisis intervention follow up.
- Mobile crisis response (MCR) follow up (age 21 and older).
- Community brief crisis support (CBCS) (age 21 and older).
- Individual placement and support (IPS) (age 21 and older).
- Personal care services (PCS) adults (age 21 and older).
- Peer support services (PSS) (age 21 and older).
- Mental health intensive outpatient program (MH-IOP) requires automated authorization (NaviNet provider portal).
- Inpatient/residential levels of care:
  - Psychiatric inpatient hospitalization.
  - Psychiatric residential treatment facility (PRTF).
  - Freestanding psychiatric hospitals institution for mental disease (IMD) for adults (ages 21 – 64).

Substance use disorder (SUD) detoxification and crisis intervention services

AmeriHealth Caritas Louisiana does not require prior authorization for SUD detox or initial crisis intervention services for the first five days (SUD detox services for days six and beyond require a prior authorization and medical necessity review).

AmeriHealth Caritas Louisiana does require that these services be authorized after completion so we 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.

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:

Level of care	Review can be completed by
BH outpatient services	Faxed form BH outpatient treatment request (OTR) or Provider Portal only
BH psychological and neuropsychological testing	Faxed form (BH psychological/neuropsychological testing form) or Provider Portal only
Child and adolescent MHRS	Faxed form (child and adolescent MHRS Form) or Provider Portal only
Adult MHRS	Faxed form (adult MHRS Form) or Provider Portal only
Crisis intervention follow up	Faxed form, Provider Portal or telephonic review
ECT	Telephonic review only
SUD IOP	Faxed form (MH Inpatient (IP)-SUD Treatment Form) or Provider Portal only
MH IOP	Provider portal only.
SUD residential or halfway house services	Faxed form(MH IP-SUD Treatment Form), Provider Portal or telephonic review
Psychiatric inpatient hospitalization	Faxed form (MH IP-SUD Treatment Form), Provider Portal or telephonic review
PRTF and Therapeutic Group Home (TGH)	Faxed form (PRTF Request Form) only for all initial requests and telephonic review for continued stay requests
Applied behavior analysis (ABA)	Faxed form (ABA Treatment Request for a Functional Assessment and/or ABA Treatment Request Form) or Provider Portal only

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 services is available by telephonic review 24 hours a day, seven days a week, 365 days a year.

Level of care	Review completed by
BH outpatient services	80% within two business days and 100% within 14 calendar days
Therapeutic group home	80% within two business days and 100% within 14 calendar days
BH psychological and neuropsychological testing	80% within two business days and 100% within 14 calendar days
Assertive community treatment (ACT), multisystemic therapy (MST), and crisis intervention follow-up services	80% within two business days and 100% within 14 calendar days
Community psychiatric support and treatment and psychosocial rehabilitation services, family functional therapy (FFT/FFT CW), homebuilders (HB)	Five calendar days from date all clinical received.
ECT	Two business days from date all clinical received
SUD IOP	Two business days from date all clinical received
SUD residential or halfway house services	24 hours from date all clinical received
Psychiatric inpatient hospitalization	24 hours from date all clinical received
PRTF	Pre-screen completed within 24 hours from date all clinical received
Applied behavior analysis (ABA)	80% within two business days and 100% within 14 calendar days

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 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.

Behavioral health outpatient therapy (BH OPT) services

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**.

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.
- MH IOP.
- PSS.
- IPS.
- PCS.
- CBCS.
- 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.
- Homicidal — 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.

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.

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 pre-screen medical necessity determination within 24 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.

Applied behavior analysis (ABA)

AmeriHealth Caritas Louisiana requires prior authorization for all applied behavior analysis (ABA) services.

Prior to requesting ABA services, the recipient must have documentation indicating medical necessity for the services through a completed comprehensive diagnostic evaluation (CDE) that has been performed by a qualified health care professional (QHCP). Per the LDH ABA Provider Manual, if a functional behavioral assessment is being requested, the CDE must include:

- A thorough clinical history with the informed parent or caregiver, inclusive of developmental and psychosocial history.
- Direct observation of the recipient, to include but not be limited to assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors.
- A review of available records.
- A valid Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 (or current edition) diagnosis.
- Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services.
- Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs, or other diagnostic evaluations considered clinically appropriate and/or medically necessary.
- When there is lack of clarity about the primary diagnosis, comorbid conditions, or medical necessity of services, the following assessments should be included as part of the CDE and be member-specific to age and abilities:
  - Autism-specific assessments.
  - Assessments of general psychopathology.
  - Cognitive/development assessment.
  - Assessment of adaptive behavior.

A copy of the Comprehensive Diagnostic Evaluation is required for AmeriHealth Caritas Louisiana BH UM to review the medical necessity of a functional assessment.

Applied Behavior Analysis (ABA) Treatment Request for a Functional Assessment Form (this is only used when the functional assessment is being requested):

1. **Member and provider information:** This is completed by the provider and needs to include all requested information in order for authorization to be completed (to determine member eligibility, identity, provider contract status, etc.). Multiple providers can be listed; however, all authorizations are built and provided under the Board Certified Behavior Analyst (BCBA) and/or group practice.
2. **DSM diagnoses:** All service authorizations require a primary MH diagnosis. The provider must complete this box in its entirety. An ASD diagnosis is not a requirement for ABA services.
3. **Assessment and clinical documentation requirements:** This section lists the clinical documentation that is needed for a medical necessity determination.
4. **Treatment Request:** This section is for the providers to indicate the services and time frames they are requesting.

Applied Behavior Analysis (ABA) Treatment Request Form (this is used when the functional assessment is completed and ABA therapies are requested):

1. **Member and provider information:** This is completed by the provider and needs to include all requested information in order for authorization to be completed (to determine member eligibility, identity, provider contract status, etc.). Multiple providers can be listed; however, all authorizations are built and provided under the BCBA and/or group practice.
2. **DSM diagnoses:** All service authorizations require a primary MH diagnosis. The provider must complete this box in its entirety. An ASD diagnosis is not a requirement for ABA services.

3. **Assessment and clinical documentation requirements:** This section lists the clinical documentation that is needed for a medical necessity determination.
4. **Other services:** The provider should list out the school, preschool, early intervention, or other therapies the member may be receiving. A summary of the contact with other services is required.
5. **Treatment request:** This section is for the providers to indicate the services and time frames they are requesting.

Mental health rehabilitation services (MHRS)

AmeriHealth Caritas Louisiana requires prior authorization for all MHRS provided to children, adolescents, and adults.

The following documentation should be included when requesting child and adolescent MHRS:

- An assessment and treatment plan (if applicable). All treatment plans are due to AmeriHealth Caritas Louisiana within 30 days of the member starting services.
- The completed MHRS Treatment Request Form.

These should include the following information:

- The severity of the member's need for services.
- Reason for requesting 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, PRTFs, 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 only CPST or only PSR.

Below are instructions for completing the MHRS Treatment Request Form:

Member information: Provide all requested member information in order for BH UM to 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 currently 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's 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.
- Homicidal — 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.

- Ensure that the CALCOUS/CASII completed date is given, as well as the LMHP who completed the assessment.

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).

Treatment plan: Use this section to give information on the member's treatment plan (preliminarily).

Other symptoms:

- 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 respite or other services.

On the form, please check all that apply based on the member's 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, or abusive behaviors.**
- **Encopresis 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, and cruelty to animals.
- **Delusions, hallucinations, or 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, and assaults.
- **Persistent violation of court orders**: Examples include but are not limited to probation violation, not following curfew, and 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 within the past month:
  - Outpatient therapy services.
  - Mental health rehabilitation services.
  - Treatment foster care.
  - Residential treatment and/or therapeutic group home.
  - Psychiatric inpatient admissions.
  - Substance use disorder treatment .
  - Intensive outpatient programs.
- On the form, please check all that apply based on the member's support system within the last month:
  - **Involved in treatment and treatment planning.**
  - **Unavailable**: Formal or informal supports for the member do not exist, 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 high risk to their health/well-being due to substance use disorder, violence or crime, or mental illness.
  - **Abusive**: For example, the member is the victim of abuse or witnesses abuse.
  - **Intentionally sabotaging treatments**: For example, the member's caregivers will not take the member to scheduled appointments, have medications filled as prescribed, ensure member takes medications as prescribed, or follow medical advice.
  - **Unable to manage the intensity of the member's symptoms without a structured program.**
- Child/adolescent only: 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 provides 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, dressing, and hygiene — and should be able to do these things for themselves based on their developmental age and stage.
  - **Community living**: The member does not display appropriate self-control over their behaviors or decisions, which has resulted 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, or 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 submit additional clinical documentation if necessary with continued stay requests.

It is imperative that you submit an updated treatment plan for all continued stay requests for MHRS to indicate progress and need for further treatment.

- On the form, please check all that apply based on the member's 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 or work problems that could result in suspension or expulsion.
  - Arrest.
  - Neglecting ADLs and/or needs monitoring of ADLs.
  - An after-hours crisis.

Eligibility requirements for mental health rehabilitation services (MHRS)

Child and Adolescent Level of Care Utilization System (CALOCUS) and Level of Care Utilization System (LOCUS):

- All child and adolescent members ages 6 to 20 receiving MHRS (except members in functional family therapy, home builders, and multi-system therapy) must have a CALOCUS completed by an LMHP when starting services, every 180 days, and upon discharge.
- All adult members ages 21 and older must have a LOCUS completed by an LMHP when starting services, annually, and upon discharge.
- All adult members receiving community psychiatric supportive treatment (CPST) and psychosocial rehabilitation services (PRS) must have a LOCUS score of three or higher on both the level of functioning domain and level of care (for members continuing services, a LOCUS score of two or lower will be considered if they have long-standing deficits with no acute changes and if they had previously had a LOCUS score of three or higher).
- All CALOCUS/LOCUS assessments must be supported by clinical documentation each and every time one is submitted for a review to AmeriHealth Caritas Louisiana BH UM.

Assessment and treatment planning:

- All members must have evidence of a clinical assessment every 365 days.
- All members must have evidence of a treatment plan completed and submitted to AmeriHealth Caritas Louisiana Behavioral Health within 30 days of starting services.
- All members must have a treatment plan updated every 365 days.

Diagnosis:

- An adult with a diagnosis of a substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis does not meet criteria for adult mental health rehabilitation services.
- All adult members receiving community psychiatric supportive treatment (CPST) and psychosocial rehabilitation services (PRS) must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:
  - Basic daily living (e.g., eating or dressing).
  - Instrumental living (e.g., taking prescribed medications or getting around the community).
  - Participating in a family, school, or workplace.

Member Choice Form:

- All members (except members receiving tenancy support through permanent supportive housing) must have a signed Member Choice Form (signed by the member and provider) prior to starting MHRS or when transferring from one MHRS provider to another.

If there are any questions regarding the eligibility requirements outlined above, please see the Louisiana Department of Health Behavioral Health Services Provider Manual located at **www.lamedicaid.com > Providers.**

Appendix

Samples of treatment request forms

1. Behavioral Health Outpatient Treatment Request Form
2. Behavioral Health Psychological and Neuropsychological Testing Request Form
3. Addiction and Psychiatric Inpatient Services Form (Behavioral Health Clinical Fax Form)
4. Psychiatric Residential Treatment Facility Authorization Request Form
5. Applied Behavioral Analysis (ABA) Treatment Request for a Functional Assessment Form
6. Applied Behavior Analysis (ABA) Treatment Request Form
7. Adult Mental Health Rehabilitation Services Form
8. Child/Adolescent Mental Health Rehabilitation Services Form

AmeriHealth Caritas Louisiana

www.amerihealthcaritasla.com

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	
Patient name: AmeriHealth Louisiana	Date of birth: 1.1.2000
Medicaid/health plan number: 123456789	Last authorization number (if applicable): NA

Provider information		
Provider name: Health Rouge	❑ PAR ❑ NON PAR ☑ In credentialing process	
Group/agency name: Healthy Health	Provider credential: ❑ MD ❑ PhD ☑ LMHP ❑ LAC ❑ NP ❑ Other, please specify:	
Physical address: 987 Healthy Way Baton Rouge, L	Telephone number: 789.456.1236	Fax number: 789.456.1234
Medicaid/Provider/NPI #: 987654321	Contact name: Patty Date	

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:	Tobacco abuse:	Gaming abuse:
☑ None ❑ By history or ❑ Current/active	☑ None ❑ By history or ❑ Current/active	☑ 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

Current risk/lethality					
Suicidal	☑ 1 none	❑ 2 low	❑ 3 moderate	❑ 4 high	❑ 5 extreme
Homicidal	☑ 1 none	❑ 2 low	❑ 3 moderate	❑ 4 high	❑ 5 extreme
Assault/violent	☑ 1 none	❑ 2 low	❑ 3 moderate	❑ 4 high	❑ 5 extreme

Medications: Is the member prescribed medications?	**Is the member compliant with medications?**
❑ Yes ☑ No Prescribing physician(s) name(s): NA	❑ Yes ☑ No Please list medications and dosages: NA

Treatment plan and goals	
List primary complaint/problem to be addressed: Cope with anxiety	Overall progress toward goals: ☑ 1 none ❑ 2 minimal ❑ 3 moderate ❑ 4 met
List measurable treatment goals: Decrease anxiety symptoms by 50%	Compliance with treatment: ☑ 1 none ❑ 2 minimal ❑ 3 moderate ❑ 4 met

Treatment request

☑ Individual ☑ Group ☑ Family ❑ Med management ❑ ECT (call BH UM for PA)

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-netwo

Participating provider

1. Specialty of provider to meet the needs of the member: NA
2. Continuity of care concerns: NA
3. Accessibility/availability of provider: NA
4. Clinical rationale: NA

Page 2 of 3

Behavioral Health Outpatient Treatment Request Form

Total sessions requested: 24 Frequency of visits: 1 per week CPT codes: 90832	Start date: 2.2.2016 Estimated end date: 7/19/2016
Provider signature: Provider Signature	Date: 2.1.2016

Page 3 of 3

ACLA-1522-93

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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**

Member information		
Patient name: Hart Smith	Health plan: AmeriHealth Caritas	Date of birth: 2.2.2000
Social security #: 987-65-3214	Patient ID or MAID ID #: 987654321	Referral source: BH Outpatient Therapist

Provider information		
(Please indicate by checking below, whether requested services should be authorized to the provider or agency.)		
☑ Provider ❑ Group/agency Name: Dr. Johnson		Provider credential: ❑ MD ☑ PhD ❑ Other, please specify:
Physical address: 963 Health Way Baton Rouge, LA	Telephone number: 741.852.9632	Fax number: 741.852.9631
Medicaid/TPI/NPI #: 741852963		Tax ID #: 741852963

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		
Axis I	300.0	R/O
Axis II	Deferred	
Axis III	None	
Axis IV	NA	
Axis V	Current	Past year

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:

Name/strength	Directions
Prozac 20 mg	Daily

What are the current symptoms prompting the request for testing?

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

Comments/explain:

Page 2 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

Start date MM/DD/YY	Stop date MM/DD/YY	CPT code	Modifier(s)	Units requested
2/15/16	5/15/16	96101	NA	5 hours

Behavioral Health Psychological/Neuropsychology Testing Request Form

Please list the tests planned to answer the clinical questions:				
Test	Reason for use	Educational Yes/No	Number of units requested for test	Number of units approved for test
MFAST	screening interview	No	1 hour	
KBIT-2	intelligence	No	3 hours	
Thomatic Test	personality	No	1 hour	
Indicate the total number of units (hours) requested: 5 hours				

Provider signature: Provider Signature Date: 2/2/16

Page 4 of 4

ACLA-1522-95

AmeriHealth Caritas Louisiana

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

Type of review:	☑ Precertification	☐ Continued stay	Estimated length of stay 30-60 days (days/units)
Type of admission:	☐ Mental health inpatient (MH-IP)	☑ Substance use rehab ☐ Substance use detox ☐ Substance use halfway house	☐ Partial hospitalization program (PHP)/day treatment ☑ Substance use intensive outpatient program (SU IOP)
Admission status:	☑ Voluntary	☐ Involuntary commitment	Readmission within 30 days? ☐ Yes ☑ No

Member information

Last, first, MI: Caritas, Health Date of birth: 3.3.1977

Member's address: 789 Caritas Rd Baton Rouge, LA Eligibility ID: 987654321

Emergency contact (other than primary caregiver): You Caritas Phone: 321654987

Legal guardian/parent: NA Phone: NA

Provider information

Facility/provider name: Road to Recovery NPI/tax ID: 741852963 Provider ID: 741852

Facility/provider address: 123 Recovery Rd. New Orleans, LA Attending M.D.: Dr. Jon Smith

Utilization Management review contact: Henry Henrietta Phone: 963.852.7412

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 (BH-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

Medication name	Dosage	Frequency	Date of last	Type of change
Prozac	10mg	TID	1.1.2016	☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
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

Previous MH/SU inpatient, rehab, detox: Detox in 1999, SA rehab in 1999

Outpatient treatment history: SUD IOP 1999

Is the member attending therapy and groups? ☐ Yes ☑ No

Explain clinical treatment plan: relapse prevention, family, individual group therapy, self-help support

Family involvement/support system: wife has agreed to attend family sessions

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 SU IOP, PHP/day treatment, SU detox and SU rehab

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

(Continued on next page)

Behavioral Health Clinical Fax Form

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

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

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana

Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

Fax completed form to the AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (BH UM) department at **1-855-301-5356**. If you have any questions, please contact BH UM at **1-855-285-7466**.

All PRTF authorizations are based on medical necessity of services. The below supporting clinical documentation must be submitted with the PRTF Authorization request form. **All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide a medical necessity determination to BH UM. Failure to submit all clinical documentation may result in a processing delay.**

1. The request must include the below supporting documentation to be reviewed for medical necessity:
    a. Most recent psychosocial and/or diagnostic assessment by an licensed mental health practitioner (LMHP) within the last six months.
    b. Court order for placement and custodial orders, if applicable.
    c. Most recent IEP/504 plan, if applicable.
    d. Psychological and/or neuropsychological testing, if applicable.
2. Upon receiving all clinical information, BH UM will schedule a telephonic review to determine medical necessity. The telephonic review must include the LMHP who has completed a face-to-face assessment/session with the member.

Referral information		
Date of referral: 12/1/2018	Referral contact: Jane Doe	
Referring facility/agency: Doe BH Counseling	Phone: 888.444.4444	Fax: 888.444.4441

Demographic information (please print)			
Child's name: Janice Doe	Date of birth: 1/1/2004	Age: 14	Medicaid ID: 123456789
Ethnicity: Caucasian	Language: English	Diagnosis: F91.3	
Home address and phone number: 0000 Doe Way			
City: New Orleans	State: LA	ZIP: 12345	
Custody (Department of Children and Family Services [DCFS], parents, other family, juvenile court, other agency): parents			
Name of custodian: Ron Doe	Relationship: Father	Phone: 888.111.1111	

LMHP recommending PRTF level of care	
Provider name: Bryce Doe LPC	Phone: 888.777.7777
Contact person: Bryce	Phone: same as above
NPI or tax ID number: 123456789	Fax: 888.777.7771
Date the LMHP completed a face-to-face assessment or session with the member? 11/28/2018	
What is the member's current status or placement? Member is currently living at home with parents and attending outpatient therapy. Member was recently discharged from acute BH IP.	

Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

Reason for referral		
Current mental health and/or substance use disorder symptoms (frequency, dates, or consequences that led to a referral for PRTF): aggressive behaviors towards mom, depressive symptoms, self-harming		
What are the contributing factors to the main clinical need or problem? attached mother, self-mutilating, and recent suicide attempt		
What are the goals for the PRTF and recommended interventions for the contributing factors indicated above? stabilize member's symptoms with particular focus on aggression and self-harming actions		
Current living situation: at home with parents		
Family history (psychiatric, substance use, domestic violence, family stressors, etc.): maternal grandmother: schizophrenia		
Family's role in treatment: family has been involved in weekly family therapy sessions for the past 5 weeks		
DCFS, JOC, Legal FINS, or OJJ involvement? ☐ Yes ☑ No If yes, indicate type:	Contact name:	Phone number:
Child's current grade level: 9th grade	Current school: homeschooled	Special education classification? ☐ Yes ☑ No
Academic, behavioral, or social functioning in school (note any suspensions or expulsions): none noted		

All medication	Dose	Schedule	Prescribing M.D.	Target symptoms
Clonodine	0.1 mg	BID	Dr. Doe	aggression
Prozac	10 mg	Daily	Dr. Doe	Depression

Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

Treatment history	Yes/no/unknown	Provider	Service date
Psychiatric hospitalization	☑ Yes ☐ No ☐ Unknown	BR Psych Hospital, WR Psych Hospital	11/2018 and 5/2016
Substance use treatment	☐ Yes ☑ No ☐ Unknown		
Mental Health Reporting System (MHRS)	☑ Yes ☐ No ☐ Unknown	Best MHRS Provider	stopped in 5/2018
Coordinated System of Care (CSOC)	☐ Yes ☑ No ☐ Unknown		
Psychiatric Residential Treatment Facility (PRTF)	☐ Yes ☑ No ☐ Unknown		
Therapeutic group home	☐ Yes ☑ No ☐ Unknown		
Crisis stabilization	☐ Yes ☑ No ☐ Unknown		
Therapeutic foster care	☐ Yes ☑ No ☐ Unknown		
Psychological and/or neuropsychological testing	☐ Yes ☑ No ☐ Unknown		
Medical treatments/concerns	☐ Yes ☑ No ☐ Unknown		

A medical necessity determination will be made after a review of all required clinical information and a telephonic review. Once a medical necessity determination is made, the referral source and/or PRTF — if one has accepted the member — will be notified within 48 hours of the determination. If the PRTF admission is determined medically necessary and a PRTF placement has not been solidified, this will be required of the referral source.

AmeriHealth Caritas Louisiana

ACLA-1735410

Page 3 of 3

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Applied Behavioral Analysis (ABA) Treatment Request for a Functional Assessment 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 (BH) Utilization Management (UM) team at **1-855-301-5356**. For assistance, please call **1-855-285-7466**.

Member information	
Patient name: Lilly Doe	Legal guardian: Julian Doe
Member date of birth: 12.12.2012	Medicaid/health plan #: 123456789

Provider information		
Group/agency name: ABA Way	☑ In network ☐ Out of network ☐ In credentialing process	
Provider name: Holly ABA LCSW, LBA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☑ LBA ☐ SCABA ☐ Tech	
Provider name: Jo ABA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☑ Tech	
Provider name: Lo ABA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☑ Tech	
Provider name: Natalie ABA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☑ Tech	
Physical address: 1234 ABA Way Baton Rouge, LA	Phone number: 888.888.5555	Fax number: 888.888.5551
Medicaid/provider/NPI #: 123456789	Contact name: Holly ABA	

DSM diagnosis:		
Primary Dx: F84/299	Secondary Dx: None	Medical Dx: None

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to AmeriHealth Caritas Louisiana BH UM for a medical necessity determination.

1. Comprehensive Diagnostic Evaluation (CDE).

Treatment request:

ABA services	Units	CPT code	Time frame (weekly/monthly)	Limitation reminders
Behavior identification assessment (ABA)	4	0359T	12/1/2018-1/1/2019	4 units per authorization 1 hour units

Applied Behavioral Analysis (ABA) Treatment Request for a Functional Assessment Form

Comments/additional information:

The CDE is attached to this request.

Provider signature

My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications as applicable.

Holly ABA	LCSW, BCBA	12/1/2018
Provider signature	Credentials	Date

Applied Behavioral Analysis (ABA) 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 (BH) Utilization Management (UM) team at **1-855-301-5356**. For assistance, please call **1-855-285-7466**.

Member information	
Patient name: Lilly Doe	Legal guardian: Julian Doe
Member date of birth: 12.12.2012	Medicaid/health plan #: 123456789
Last authorization # (if applicable):	

Provider information		
Group/agency name: ABA Way	☐ In network ☐ Out of network ☐ In credentialing process	
Provider name: Holly ABA LCSW, LBA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech	
Provider name: Jo ABA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech	
Provider name: Lo ABA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech	
Provider name: Natalie ABA	Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech	
Physical address: 1234 ABA Way Baton Rouge, LA	Phone number: 888.888.5555	Fax number: 888.888.5551
Medicaid/provider/NPI #: 123456789	Contact name: Holly ABA	

DSM diagnosis:		
Primary Dx: Autism Spectrum Disorder	Secondary Dx: None	Medical Dx: None

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to AmeriHealth Caritas Louisiana BH UM for a medical necessity determination. Failure to submit all clinical documentation may result in a delay of processing this request.

1. Functional Behavioral Assessment.
2. Full Behavior Support Plan/Treatment Plan (including symptoms/behaviors requiring treatment, specific treatment interventions, and that these were indicated by the assessment tool).
3. ABA Therapy Progress Summary including cumulative graphs of progress/standard celebration charts.
4. Sample schedule of treatment.
5. Documentation of caregiver goals, involvement in treatment, and progress in skill development.

Additional information included: treatment plan

List any other services the member is receiving, including service names/therapy, number of hours per week of each, and the targets of those treatments and evidence of coordination with school, preschool, or early intervention program, and other therapy providers (coordination that is more than a phone call or notification of enrollment).

School/preschool/early intervention program:

Type of service	Number of hours/week	Behaviors/deficits targeted
None		

Other therapies provided:

Type of service	Number of hours/week	Behaviors/deficits targeted
None		

Summary of contact with other providers:

N/A

Treatment request:

Treatment start date: 12/01/2021

ABA services	Units	CPT code	Time frame (15-minute units)	Limitation reminders
Behavior identification supporting assessment		0362T		
Behavior identification supporting assessment	16	97152	26 weeks	
Adaptive behavior treatment		0373T		
Adaptive behavior treatment by protocol	2600	97153	26 weeks	
Group adaptive behavior treatment by protocol	1040	97154	26 weeks	
Adaptive behavior treatment with protocol modification	312	97155	26 weeks	
Family adaptive behavior treatment guidance	104	97156	26 weeks	
Multiple-family group adaptive behavior treatment	24	97157	26 weeks	
Guidance without patient				
Group adaptive behavior treatment with protocol modification	104	97158	26 weeks	

Provider signature

My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications as applicable.

Holly ABA	LCSW, BCBA	12/01/2021
Provider signature	Credentials	Date

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: Jill Doe	Legal guardian: NA
Member date of birth: 5.5.1967	Medicaid/health plan #: 123456789
Last authorization # (if applicable): NA (initial request)	

Provider information	
Provider name: Doe MHRS	☑ Participating ☐ Not participating ☐ In credentialing process
Group/agency name: Does MHRS Provider credential: ☐ MD ☐ PhD ☑ LMHP ☐ LAC ☐ NP ☐ Other, please specify:	
Physical address: 123 Doe Way Baton Rouge, LA	
Phone number: 888.888.3333	Fax number: 888.888.3331
Medicaid/provider/NPI #: 12356789	Contact name: Roe Doe

DSM diagnosis		
Primary Dx: F20.9/295.9	Secondary Dx: None	Medical Dx: E08
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: Dr. Trott (PCP) and Dr. Post (Psychiatrist)
If no, please explain:

Adult Mental Health Rehabilitation Treatment Request Form

	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): Dr. Post (psychiatrist)

Is member compliant with medications? ☐ Yes ☑ No

Please list medications and dosages:

Zyprexa 10mg bid, Remeron 45mg qhs, Effexor 150mg qam, Buspar 15mg tid

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

LOCUS: Date of completion: 12/1/2018	LMHP name with credentials: Susie Doe LCSW

Treatment request (please check services being requested)

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

Service code: H0036 Number of units: 4 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: 4

PSR group in the office number of units per week:

PSR group in the community number of units per week: 4

☑ **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.

Adult Mental Health Rehabilitation Treatment Request Form

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?**
Med non-comp	PSR	Med mang skills	1 hour	26	Yoe Doe
Delusions	CPST	individual therapy	1 hour	26	Susie Doe LCSW

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:

PSR focused on skills for med non-compliance, CPST focused on therapeutic techniques for delusions -

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

Member has attempted CPST/PSR in the past (last time was 2 years ago) and recently discharged from BH IP

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

Adult Mental Health Rehabilitation Treatment Request Form

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

Adult Mental Health Rehabilitation Treatment Request Form

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:

Child and Adolescent 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: Jane Doe	Legal guardian: Henry Doe
Member date of birth: 1.1.2003	Medicaid/health plan #: 123456789
Last authorization # (if applicable): NA (initial request)	
Is the member currently in coordinated system of care (CSoC)? ☐ Yes ☑ No	

Provider information	
Provider name: Doe Services	☑ In network ☐ Out of network ☐ In credentialing process
Group/agency name: Doe Services Provider credential: ☐ MD ☐ PhD ☑ LMHP ☐ LAC ☐ NP ☐ Other, please specify:	
Physical address: 123 Doe Dr. Baton Rouge, LA	
Phone number: 888.888.9999	Fax number: 888.888.9991
Medicaid/provider/NPI #: 123456789	Contact name: John Doe

DSM diagnosis		
Primary Dx: F32/296.2	Secondary Dx: None	Medical Dx: None
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: Susie Brown LPC, Dr. Word (PCP)
If no, please explain:

Child and Adolescent Mental Health Rehabilitation Treatment Request Form

	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): Dr, Word (PCP)

Is member compliant with medications? ☑ Yes ☐ No

Please list medications and dosages:

Adderral XR 10 mg daily

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

CALOCUS/CASII: Date of completion: 12/1/2018	LMHP name with credentials: John Doe LPC

Treatment request (please check services being requested)

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

Service code: H0036 Number of units: 2 per week

☐ **Therapeutic group home (TGH):** Community-based residential services in a home-like setting.

Service code: Number of units: per week

☐ **Home builders (HB):** Provides youth from birth through 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.

Service code: Number of units: per week

☐ **Multi-systemic therapy (MST):** Provides youth from 12 through 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.

Service code: Number of units: per week

☐ **Family functional therapy (FFT or FFT-CW):** For youth from birth through 18 years old, targeting behaviors that impact family functioning.

Service code: Number of units: per week

Child and Adolescent Mental Health Rehabilitation Treatment Request Form

☐ **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: 2

PSR individual in the community number of units per week:

PSR group in the office number of units per week: 4

PSR group in the community number 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.

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 last 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?**
Fighting at school	PSR	anger management	1.5 hours	12 weeks	David Doe
Depression	CPST	individual therapy	.5 hours	26 weeks	John Doe LPC

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:

PSR provides anger management skills to address fighting at school; CPST provides therapy to help address depressive symp

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

Member has received prior behavioral health outpatient services and symptoms have remained with little improvement

Child and Adolescent Mental Health Rehabilitation Treatment Request Form

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:

- ☑ Angry outbursts/aggression that is unmanageable
- ☐ Arrest/confirmed illegal activity
- ☐ Cruelty to animals
- ☐ Daredevil and/or impulsive behaviors
- ☐ Delusions/hallucinations
- ☑ Destruction of property
- ☐ Disorganized thoughts, speech, or behavior
- ☐ Encopresis and feces smearing
- ☐ Fire setting
- ☐ Hypomanic or hypermanic symptoms increased and/or psychomotor agitation
- ☐ Non-suicidal self-injury
- ☐ Obsessions or compulsions
- ☐ Persistent violation of court orders
- ☐ Repeated running away for more than 24 hours
- ☐ Sexually inappropriate/ aggressive/abusive/threatening
- ☐ Suicidal ideations

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):

- ☐ Coordinated system of care (CSoC)
- ☐ Mental health rehabilitation services (CPST, PSR, HB, FFT, MST)
- ☑ Outpatient therapy services
- ☐ Psychiatric inpatient admission(s)
- ☐ Residential treatment
- ☐ Substance use disorder treatment
- ☐ Therapeutic group home
- ☐ Treatment foster care

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):

9. 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/adolescent)

Page 4 of 6

Child and Adolescent Mental Health Rehabilitation Treatment Request Form

10. 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):

- ☐ Depressed mood with associated symptoms
- ☐ Disruptive behaviors (check all that apply):
  - ☐ Cruelty to animals
  - ☐ Destruction of property
  - ☐ Distractibility
  - ☐ Serious rule violations
  - ☐ Stalking
  - ☐ Theft
- ☐ Has been arrested
- ☐ Has had an after-hours crisis
- ☐ Has interpersonal conflicts (check all that apply):
  - ☐ Anger outburst
  - ☐ Hostile/intimidating
- ☐ Manipulative
  - ☐ Poor boundaries
- ☐ Has ongoing isolation and/or inappropriate social behaviors
- ☐ Has school problems resulting in suspensions or expulsion
- ☐ Hypomanic symptoms
- ☐ Is neglecting ADLs and/or needs monitoring for ADLs
- ☐ Obsessions/compulsions
- ☐ Psychiatric medication noncompliance
- ☐ Psychosis
- ☐ Post-traumatic stress disorder or history of trauma
- ☐ Suicidal and/or homicidal ideations (with or without intent)

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?**

Child and Adolescent Mental Health Rehabilitation Treatment Request Form

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:

Acronym index

Applied behavioral analysis **ABA**

Activites 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 brief crisis support **CBCS**

Community psychiatric supportive treatment **CPST**

Diagnostic and Statistical Manual **DSM**

Electroconvulsive therapy **ECT**

Functional behavior analysis **FBA**

Functional family therapy **FFT**

Home builders **HB**

Individual placement and support **IPS**

Intensive outpatient program **IOP**

Mental health rehabilitation services **MHRS**

Mobile crisis response **MCR**

Multi-system therapy **MST**

Peer support services **PSS**

Personal care services **PCS**

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 March 2022

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You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services 24 hours a day, seven days a week, at **1-888-756-0004 (TTY 1-866-428-7588**).

Usted puede tener esta información en otros idiomas y formatos sin costo alguno para usted. También puede recibir la interpretación por teléfono en cualquier idioma. Llame a Servicios al Miembro al **1-888-756-0004 (TTY 1-866-428-7588)** las 24 horas del día, los siete días de la semana.

Quý vị có thể có thông tin này bằng các ngôn ngữ và định dạng khác miễn phí. Quý vị cũng có thể yêu cầu thông dịch thông tin này ra bất kỳ ngôn ngữ nào qua điện thoại. Xin gọi ban Dịch vụ Hội viên phục vụ 24 giờ/ngày, 7 ngày/tuần, theo số **1-888-756-0004 (TTY 1-866-428-7588).**

ACLA-19518466

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