PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MENTAL HEALTH INTENSIVE OUTPATIENT (MH-IOP: S9480) and MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM (MH-IOP: H0035)

CONTINUED STAY Service Authorization Request Form

Please be mindful of notes through this form that provide reference to where information requested herein aligns with documentation from the updated Comprehensive Needs Assessment (CNA) and/or Individualized Service Plan. Character limits have been established in most sections, please use the note section to add additional information.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:		Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name and Credentials*:	
		Phone #	
		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Type of Service Authorization Request:

Mental Health Intensive Outpatient {S9480}
Mental Health Intensive Outpatient with Occupational Therapy {S9480, GO}. Please place evidence of the need for OT Services in the Notes Section of this form.
Mental Health Partial Hospitalization Program {H0035}

Initial date of admission to current service:	**Average units provided per week:**

Request for Approval of Continued Services: **Retro Review Request?** Yes No

From_____(date), To_____(date), for a total of_____units of service.

Plan to provide_____hours of service per week.

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Medication Update

Name of Medication	Dose	Frequency	For any changes, note if: New, Ended or Changed in dose/frequency from last authorization

Member Full Name: Medicaid #:

SECTION I: CARE COORDINATION

Please list all medical/behavioral services or community interventions/supports the individual has participated in since the last Authorization, as well as any changes:

Name of Service/Support	Provider Contact Info	Frequency	*For any changes, note if:* New, Ended or Changed in frequency/intensity from last authorization

Describe Care Coordination activities with these other services/supports since the last authorization.

SECTION II: TREATMENT PROGRESS

Along with this document, please include the updated Individual Service Plan (ISP) that reflects the current goals and interventions, the original Comprehensive Needs Assessment (CNA), and an addendum to the CNA (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery. For improved alignment and reduction in duplication of work, we suggest using the Enhanced Services ISP Template. As a reminder, this ISP should include the following information:

- **Treatment goals** designed with the individual that are person-centered, recovery-oriented, and trauma-informed.
  - Service providers should write these goals in collaboration with the individual and thus the goals should use words that are understandable and meaningful to the individual.
  - Treatment goals should leverage individual strengths and should address barriers to participation in care.
  - If the individual has experienced trauma, the provider should assure that interventions reflect and address the impacts of those experiences.
- **Objective Measures** for each treatment goal to monitor and demonstrate progress.
  - The metrics used for these objectives should be meaningful and relatively easy to track.
  - Avoid use of percentages unless that percent completion is obvious and easily computed.
  - Objectives should include frequency counts of observable behaviors and severity ratings of behavior if these ratings have established anchors on a scale to support accuracy (e.g. 0 = not observed/experienced in the last week, 5 = observed/experienced nearly all day, every day this week). Frequency ratings can indicate severity, but not in all cases and so measuring both how often problem behaviors are happening as well as how severe or impairing they are allows for optimal tracking of progress.
  - Description of how this objective will be measured (e.g. how often will they be measured and by whom, how will the tracking be logged and where)
  - Standardized, evidence-based assessments (or composite scales) are acceptable so long as they reflect the goal being measured. (E.g. Goal is related to reduction of depression symptoms and then measured by the Personal Health Questionniare-9 (PHQ-9)).
- **Interventions** that seek to address the needs for services and support progress towards specific goals.
  - Providers should describe interventions in terms of the activities involved, the skills these activities promote/develop, and any necessary adaptations to standard intervention that will be necessary for this individual's culture, identity, or personal preferences.

- Interventions should seek to achieve or maintain stability in the least restrictive environment possible. Thus, if a provider conducts an intervention in a more restrictive than natural environment (e.g. clinic), part of the intervention should be to translate the use of skills to the least restrictive environment (e.g. community).
- If more than one provider type is involved in the delivery of the service, the provider should list interventions specific to the scope of each relevant provider type in addressing the treatment goal and measuring progress.

- **Dosage of Intervention**
  - Treatment plan should include a description of the frequency in terms of days/hours the providers will deliver the interventions.
- **Treatment Progress**
  - Providers should describe progress in terms of the identified goals and objectives.
  - Providers should describe any alterations in goals or whether new goals have been established and why.
  - Goals and measurement may change over time as the provider's understanding of the problem evolves and/or as the individual may disclose new information or exhibit new behaviors that impact goals.
  - Continued stay authorization requires explanation of how the plan is evolving and how it will support recovery for the individual.
- **Resources and Strengths**
  - The treatment plan should include individual strengths, preferences, and resources that the individual identifies as relevant to their recovery.
- **Barriers**
  - The treatment plan should include a list of ongoing or evolving barriers to treatment, additional resources that would support the individual in overcoming these barriers, and a plan for how to address them.

Section V: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the individual has made sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan. ***These responses should reflect any updated understanding of the recovery and discharge plan since the last review.***

What would progress/recovery look like for this individual?

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

What is the best estimate of the discharge date for this individual? _____

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date(s): _____

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____

Date: _____

Notes Section

Member Full Name: Medicaid #: