Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

EPSDT Behavior Therapy INITIAL Authorization Request Form

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:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian:		Clinical Contact Name & Credentials*:	
Parent/Guardian Contact Information:		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

Admission Date:	
Request for Approval of 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.	
Is this a new service for the member? ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)	
Primary ICD-10 Diagnosis	
Secondary Diagnosis	
Number of weekly hours requested for clinical supervision:	
Name and NPI of clinical supervisor: ,	
Number of weekly hours for Service Coordination:	
Name and NPI of Services Coordinator (if applicable): ,	
Number of weekly hours of direct service by unlicensed staff:	
Name and NPI of licensed staff delegating authority to the unlicensed staff: ,	
Number of weekly hours of direct service by Licensed Staff:	
Name and NPI of licensed staff: ,	

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Referral source – Must be a physician, nurse practitioner or physician assistant who is the child's primary care provider or another physician, nurse practitioner, or physician assistant provider familiar with the developmental history and current status of the child.					
Name	Profession	Address	Phone	Diagnosis (ICD-10)	Email Address
	☐ Physician ☐ Nurse Practitioner ☐ Physician Assistant				

Name of Medication	**Dosage**	**Frequency**
If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.		

SECTION I: EPSDT BEHAVIOR THERAPY TREATMENT ELIGIBILITY CRITERIA	
The individual has a level of impairment which requires treatment that cannot be provided by another DMAS program or a lower level of care/service and requires behavioral interventions and the expertise of a LMHP or a LBA or LABA. CMHRS services are not allowed concurrently with behavior therapy.	☐ Yes ☐ No
The individual must have a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that is relevant to the need for behavioral therapy or have a provisional psychiatric diagnosis as developed by an LMHP when no definitive diagnosis has been made;	☐ Yes ☐ No
Is the member and their family willing to participate in services?	☐ Yes ☐ No
What, if any, are the barriers to participation?	
Individual must meet TWO of the following:	
Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language	☐ Yes ☐ No
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	
Severe impairment in social interaction/social reasoning/social reciprocity/ and interpersonal relatedness	☐ Yes ☐ No
Describe the evidence for, and effects of this issue on the member's life:	

What other interventions have been tried/considered?	
Why were they ruled out?	
Frequent intense behavioral outbursts that are self-injurious or aggressive towards others	☐ Yes ☐ No
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	
Disruptive obsessive, repetitive, or ritualized behaviors.	☐ Yes ☐ No
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	
Difficulty with sensory integration	☐ Yes ☐ No
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	

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SECTION II: CARE COORDINATION	
Primary Care Physician:	
Are there medical health concerns that could affect the behavioral health issues? If yes, explain:	☐ Yes ☐ No
Plan to coordinate with primary care physician to help ensure medical concerns are addressed in relation to behavioral health treatment:	

SECTION III: TRAUMA-INFORMED CARE	
Trauma-Informed Care (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)	
Is there evidence to suggest this member has experienced trauma?	☐ Yes ☐ No
What is your plan to assess/refer and address the current and potential effects of that trauma?	

SECTION IV: INDIVIDUAL TREATMENT GOALS
SERVICE REQUIREMENTS
Preliminary Treatment Plan: (must address the areas listed below delineated in the EPSDT Behavioral Therapy Program provider manual preliminary treatment plan Section as well as any identified barriers to participation)
Child-focused Behavior change goals:
How many hours per week will be focused on the child behavior change goals? **Breakdown of total weekly hours requested** Number of hours for direct therapy time: Number of hours for clinical supervision: Number of hours for service coordination: Other (list type of activity and hours):
Parent and caregiver goals:
How many hours each week will at least one family member be committed to participate in treatment:
Service Coordination goals:

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SECTION V: DISCHARGE PLANNING		
DISCHARGE PLAN (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)		
Step Down Service/Supports	Identified Provider/Supports	Plan to assist in transition
Recommended level of care at discharge:		

Estimated Date of Discharge:

The Service Specific Provider Intake has been completed by an LBA/LMHP Type and the individual's psychiatric history information reviewed. By my signature (below) I am attesting that the individual meets the medical necessity criteria for the identified service.

Signature (actual or electronic) of LMHP Type/LBA:

Printed Name of LMHP Type/LBA:

Credentials & NPI:

Date:

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NOTES SECTION
If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.

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PLEASE SEND FORM TO THE DESIGNATED HEALTH CARE PLAN USING THE CONTACT INFORMATION BELOW FOLLOWING THE TIME FRAME REQUIREMENTS ALSO BELOW

All MCOs rely on Contract Standards; 3 business days or up to 5 business days if additional information is required.

CONTACT INFORMATION			
Commonwealth Coordinated Care (CCC) Plus	Phone Number	Fax Number	Web Portal
Aetna Better Health of Virginia	855-652-8249	866-669-2454	https://www.aetnabetterhealth.com/virginia/providers/portal
Anthem HealthKeepers Plus	800-901-0020	866-877-5229	https://mediproviders.anthem.com/va/pages/precert.aspx
Molina Complete Care	800-424-4524	(855) 339-8179	www.MCCofVA.com
Optima Health Community Care	888-946-1168	844-348-3719 (BH Inpatient) 844-895-3231 (BH Outpatient)	www.optimahealth.com
United Healthcare	877-843-4366	855-368-1542	www.providerexpress.com
Virginia Premier Health Plan	844-513-4951	888-237-3997	Pending/TBA 4/1/2018

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INITIAL REQUEST	Registration vs. Authorization CONTINUED STAY REQUEST
Mental Health Case Management	H0023	R	R
Mental Health Peer Support Services – Individual	H0025	R	A
Mental Health Peer Support Services – Group	H0024	R	A
Crisis Intervention	H0036	R	A
Crisis Stabilization	H2019	R	A
Intensive Community Treatment	H0039	A	R
Intensive In-Home	H2012	A	A
Therapeutic Day Treatment for Children * TDT School Day	H0035 *HA	A	A
Therapeutic Day Treatment for Children * TDT Afterschool	H0035 *HA *UG	A	A
Therapeutic Day Treatment for Children * TDT Summer	H0035 *HA *U7	A	A
Day Treatment / Partial Hospitalization * Adults	H0035 *HB	A	A
Mental Health Skill-building Services (MHSS)	H0046	A	A
Psychosocial Rehab	H2017	A	A
EPSDT Behavioral Therapy (ABA)	H2033	A	A

Timeframe Requirements for Submission (Concurrent)	CMHRS Services (excluding CI/CS)	CI/CS
Aetna	7 business days	48 hrs.
Anthem	14 business days	48 hrs.
MCC	7 business days	48 hrs.
Optima	7 business days	48 hrs.
United Healthcare	14 business days	48 hrs.
Virginia Premier	14 business days	48 hrs.