



Obtaining Authorization for Services

This chapter describes the procedures that treatment providers must follow to obtain authorizations for treatment of Department of Behavioral Health/Community Behavioral Health (DBH/CBH) clients. The process of coordinating client care is at the core of the managed care concept. Authorizing services enables the managed care organization to have knowledge of the needs of its clients, the capacities of its provider network, and the extent of its fiscal responsibilities.

The authorization process involves the following steps:

- ▶ verifying that the individual is eligible for the services requested
- ▶ assessing the needs of clients, consistent with medical necessity criteria
- ▶ obtaining the initial authorization to begin treatment
- ▶ assessing progress or utilization of the services as they are provided

DBH/CBH clients with behavioral health needs must have ready access to the most appropriate treatment service and level of care. DBH/CBH utilizes the Commonwealth of Pennsylvania's Medical Necessity Criteria in issuing service authorizations. **(A copy of HealthChoices Behavioral Health RFP, Appendix T is available from upon request by calling CBH Provider Relations at (215) 413-7660.)** The length of an authorization is never based solely on diagnosis or type of illness/condition. We strive to ensure that:

- ▶ care is provided in the most appropriate and least restrictive setting
- ▶ authorizations are standardized, coordinated and expedited
- ▶ length of stays that are not medically warranted are prevented
- ▶ costs are controlled

Categories of Authorization for Service:

1 THE FOLLOWING CLINICAL SERVICES CANNOT BEGIN WITHOUT PRIOR AUTHORIZATION:

- ▶ all inpatient behavioral health services
- ▶ all detoxification, residential rehabilitation, and half-way house services
- ▶ all psychiatric acute partial hospitalization services for adults and children
- ▶ all Behavioral Health Rehabilitation Services (BHRS)
- ▶ all residential treatment services for children and adolescents
- ▶ all psychological testing
- ▶ all out-of-plan or out-of-area services
- ▶ community support services
- ▷ This clinical category includes initial and concurrent treatment episodes.
- ▷ Providers must follow the authorization process outlined under **Services than Cannot Begin Without Prior Authorization.**
- ▷ Community Support Services (TCM, Crisis Residences and Family-Based are authorized through OMH/MR).

2 THE FOLLOWING CLINICAL SERVICES CAN BEGIN WITHOUT PRIOR AUTHORIZATION BUT REQUIRE AN AUTHORIZATION NUMBER FOR PAYMENT:

- ▶ all maintenance partial hospitalization services
- ▶ all Intensive Outpatient Provider (IOP) services
- ▶ all initial and follow-up psychiatric consultations
- ▶ all Comprehensive Biopsychosocial Evaluations (CBEs) and Re-evaluations (CBRs)
- ▶ all emergency psychiatric evaluations
- ▶ all court evaluations
- ▷ This clinical category includes initial and concurrent treatment episodes.
- ▷ Providers must follow the authorization process outlined under **Services That Begin Without Prior Authorization and Do Not Require an Authorization Number for Payment.**

3 THE FOLLOWING CLINICAL SERVICES CAN BEGIN WITHOUT PRIOR AUTHORIZATION AND DO NOT REQUIRE AN AUTHORIZATION NUMBER FOR PAYMENT:

- ▶ all outpatient mental health and drug and alcohol services
- ▶ all methadone maintenance clinic services
- ▶ all assessments
- ▶ Crisis Response Center (CRC) evaluations
- ▷ This clinical category includes initial and concurrent treatment episodes.
- ▷ Providers must follow the instructions outlined under **Services That Can Begin Without Prior Authorization and Do Not Require an Authorization Number For Payment.**

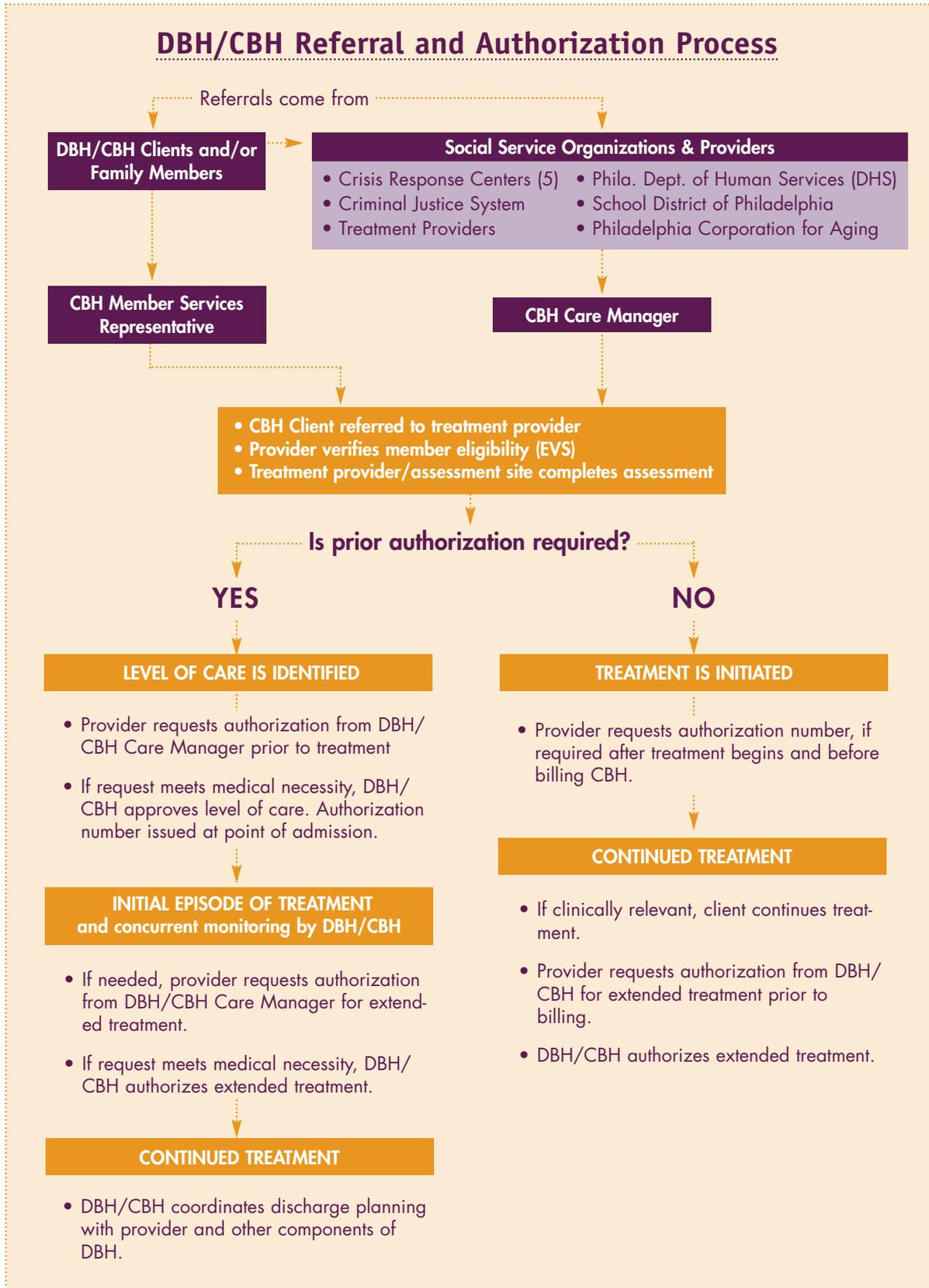
Case Open Process

Providers must request cases to be opened for CBH clients who fall in one of the categories listed below:

- ▶ Clients who are newly enrolled in Medical Assistance. This includes clients who have transferred from another county to Philadelphia and those previously funded for drug and alcohol outpatient services under the Behavioral Health Special Initiative (BHSI) and have converted to CBH.
- ▶ Clients who have never received inpatient or outpatient behavioral health services under CBH.

Providers should complete a CBH **Case Open Request Form** for clients who meet the above criteria. The forms must be submitted on a weekly basis to the Data Entry Supervisor, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Cases will be opened within two weeks from the date CBH receives the request and providers will have 90 days from the date of service to bill for services. Failure to open a case will not be cause to extend billing time frames.

This chart illustrates the ways DBH/CBH clients are referred for treatment and the steps treatment providers must take to obtain authorization.



How CBH Works with Clients and Providers

CBH assists both clients and providers as they proceed through the authorization process.

For CBH Clients Seeking Treatment

MEMBER SERVICES UNIT

The CBH Member Services Unit is available for **clients** to call when they want to schedule an initial appointment for services. The Member Services Unit is also available to assist providers in referring a client to treatment services that may more closely meet the client's needs.

This unit is responsible for:

- ▶ confirming client's eligibility
- ▶ collecting relevant demographic information about the client and reason for referral
- ▶ scheduling appointments for assessments
- ▶ determining special needs
- ▶ making referrals to treatment providers
- ▶ ensuring clients have a choice of treatment program

Member Services Representatives will always attempt to conduct a three-way call with the client and provider when scheduling an appointment at a provider site. In instances where CBH reaches the provider's voicemail, the Member Services Representative will leave a message requesting an appointment. The provider is responsible for returning the call to the Member Services Representative and providing an appointment date, time and place. CBH will then inform the client.

When clients contact the Member Services Unit during non-business hours and weekends, the Member Services Representative will call the identified provider the next working day to obtain an appointment then notify the client of the date, time, and location of the appointment.

Providers are required to cooperate with CBH in scheduling assessments.



Member Services Unit:

1-(888) 545-2600

24 hours a day, 7 days a week.

For more information about services available to members and member rights, please see the **CBH Member Handbook** (Appendix A).

For Providers Seeking Authorizations

CLINICAL MANAGEMENT

Clinical Management is available for providers to call to request treatment service authorizations, or if needed, to obtain information on other providers to whom they may refer a client. In addition, Clinical Management is responsible for:

- ▶ coordinating care
- ▶ determining level of care
- ▶ authorizing services
- ▶ conducting concurrent reviews
- ▶ maintaining a clinical liaison with providers
- ▶ resolving problems related to utilization management

When calling Clinical Management, please have as much Medical Assistance, demographic, and clinical information available as possible.

Clinical Management Information Checklist

- ▶ provider's name and facility
- ▶ demographics of client (age, marital status, race, gender)
- ▶ Axis 1-5 must include DSM IV code for Axis -1
- ▶ ICM or RC (indicate whether or not client has name, agency, or phone number of ICM or RC)
- ▶ presenting problem (includes special needs)
- ▶ Mental Status Examination (MSE) must include physician's name (in D&A cases, if MSE is not presented, indicate whether or not mental health issues exist)
- ▶ medications, dose and frequency (indicate last date of compliance or noncompliance)
- ▶ D&A history (name of drug, amount used, route of administration, duration of use, and date of last use)
- ▶ oral fluid/drug screen/blood alcohol results
- ▶ supports
- ▶ treatment plan
- ▶ living status
- ▶ legal



OBTAINING AUTHORIZATIONS FOR SERVICE

For Emergency Inpatient Mental Health and Drug & Alcohol Services

call Clinical Management 24 hours a day, 7 days a week
(215) 413-7171

For All Non-Emergent Services Requiring Prior Authorization,

call Clinical Management Monday-Friday, 8:30 am-5:00pm
(215) 413-3100

For All Non-Emergent Services Requiring an Authorization Number

Complete an **Outpatient Service Request Form** and mail it to:

Data Entry Department
CBH
801 Market Street, 7th Floor
Philadelphia, PA 19107

Beginning the Process

Verifying Member Eligibility

Prior to treatment, providers are responsible for verifying that individuals are eligible for Medical Assistance and enrolled in a Health Maintenance Organization (HMO).

The Commonwealth of Pennsylvania Department of Public Welfare issues a Medical Assistance (MA) Access card to all Medical Assistance recipients at the time they are initially enrolled in the MA program. The Pennsylvania Department of Public Welfare (DPW) maintains a list of the current status of all MA recipients and updates this list daily. Providers are required to check the member's eligibility every time service is provided.

In order to receive payment for services rendered, providers must check the member's eligibility. Providers can access the DPW's daily eligibility file by phone by calling (800) 766-5387.

Providers may also use the various methods described on DPW's website:

www.dpw.state.pa.us/omap/provinf/omapevs.asp

Utilization Review Process

Utilization Review

Utilization review is the process by which Care Management staff determine the initial level of care. This process ensures that the quality of treatment is consistent with recognized and accepted medical standards and appropriate to the client's presenting symptoms as well as physical, psychological, and social needs.

The initial review process will attempt to:

- 1 Identify drug and alcohol issues, particularly withdrawal symptoms, specific drugs used, patterns of use, consequence of use, risk factors, and medical complications related to use.
- 2 Identify psychiatric symptomatology present through observation and from information collected by the individual and/or family. This includes a Mental Status Exam (MSE) that determines the individual's thought content, judgment and insight, motor activity, sensorium, mood/affect, suicidal/homicidal ideation/plans, etc., and documents:
 - ▶ recent hospitalizations
 - ▶ current medications
 - ▶ primary physician/psychiatrist and/or treatment program in which currently enrolled
 - ▶ ICM/RC/BHSI case management
 - ▶ DHS involvement
 - ▶ trends/patterns of decompensation
 - ▶ legal involvement
 - ▶ barriers to treatment

- 3 Identify medical issues that may pose an immediate risk to the individual, and in cases of pregnant women, that may place the fetus at significant risk due to the lack of prenatal care, given the factors identified in 1 and 2 above.
- 4 Identify special needs such as medical conditions, cognitive disabilities, women with children, cultural issues/barriers, hearing and sight impairments, developmental disabilities, etc.
- 5 Identify environmental conditions that place an individual at risk of harm, reduce the opportunity for abstinence, etc. This will include issues such as recent eviction, lack of permanent housing, multiple foster placements, living with others who may be using substances, or any other factors that may inhibit or support continued symptoms.

All requests for authorization will be based on the Medical Necessity Criteria (Appendix T) of the HealthChoices Behavioral Health Program Standards (available upon request from CBH's Provider Operations at **(215) 413-7660** or on the Pennsylvania Client Placement Criteria.

Concurrent Review

Concurrent review is the process by which DBH/CBH assesses the care being given a client to insure that the treatment is clinically appropriate, effective, and adequate.

DBH/CBH may require that the agency/facility send copies of the records on which clinical recommendations are based when there is a question related to the validity of the clinical information given over the phone. The Release of Information form has already been signed by the consumer at the start of treatment to facilitate information sharing. (Please note that the provider is responsible for the cost of these copies and postage.)

The concurrent review process may result in a determination that a client needs different, additional, or lesser care than that being recommended by the current provider. This decision may be appealed according to the Authorization Appeals Procedure detailed later in this section.

Services provided to DBH/CBH clients that require prior authorization are subject to concurrent review. If the level of care changes during a service period or is specified as specialized care, a separate authorization will be issued for the new level of care. In addition, if the person needs to be transferred to a different facility or location, the facility must obtain an authorization from DBH/CBH to do so. DBH/CBH can provide information to the client and the provider about other agencies within the CBH network who provide the type of services needed. It is the current provider's responsibility to make the referral and the transportation arrangements as necessary. Please refer to **Coordination of Transportation** in the Coordinating Services section of this manual for further details.

Events which are identified to have quality of care concerns or risk issues are referred to the Manager of Quality Review and the Director of Clinical Management, who will investigate and forward the findings to the Director of Medical Affairs for review, recommendations or follow-up action.

Please see the **Care Management Unit Reference Guide** for a summary view of authorization and concurrent review information.

Services That Cannot Begin Without Prior Authorization

There are specific services that the treatment provider cannot begin providing without obtaining prior authorization. These include:

- ▶ all inpatient behavioral health services
- ▶ all detoxification, residential rehabilitation, and half-way house services
- ▶ all psychiatric acute partial hospitalization services for adults and children
- ▶ all Behavioral Health Rehabilitation Services (BHRS)
- ▶ all residential treatment services for children and adolescents
- ▶ all psychological testing
- ▶ all out-of-plan or out-of-area services
- ▶ community support services

Guidelines for Prior Authorization of Inpatient Hospital Treatment

When a DBH/CBH Care Manager reviews the Medical Necessity Criteria regarding an individual member and agrees that inpatient hospital treatment is medically necessary, they will authorize treatment under one of the following levels of care:

INPATIENT PSYCHIATRIC HOSPITAL TREATMENT

- ▶ inpatient acute
- ▶ inpatient sub-acute
- ▶ acute 302
- ▶ 23-hour bed

INPATIENT AND NON-HOSPITAL BASED DRUG AND ALCOHOL TREATMENT

- ▶ hospital and non-hospital based detoxification
- ▶ hospital and non-hospital based residential rehabilitation
- ▶ half-way house services

Authorization Guidelines for Emergency Admissions

The following are the authorization guidelines providers should follow when calling CBH on behalf of a client who is experiencing a psychiatric or drug and alcohol emergency. An emergency is defined as **Emergent** or **Urgent** and is not limited to a prescribed set of diagnoses or symptoms. An individual with an emergent condition presents with acute, severe symptoms (including severe pain) that requires immediate medical attention and that, to ignore, would result in:

- ▶ serious jeopardy to the life of the individual (or, in the case of a pregnant woman, the woman or her unborn child)
- ▶ serious impairment to bodily functions
- ▶ serious dysfunction of any bodily organ or part

Emergent care differs from urgent care in that urgent conditions, if left untreated (particularly within a 24-hour period) could become emergent. **All other situations which do not fall under emergent or urgent are considered routine.**

EMERGENT AND URGENT AUTHORIZATION PROCEDURE:

In order to be admitted to an inpatient unit, a client must be evaluated by a psychiatrist at a hospital emergency room or Crisis Response Centers (CRC) in the city of Philadelphia. This examination must include a Mental Status Evaluation (MSE). In order to be admitted to a medically managed or medically detoxification, residential rehabilitation facility or halfway house, a client should be assessed according to Pennsylvania Client Placement Criteria (PCPC).

- 1 The provider calls CBH Clinical Management at **(215) 413-7171**. Please note that the provider is not calling a specific person when calling this number, but is asking to speak with someone to present an individual for psychiatric or drug and alcohol admission.
- 2 The Care Manager will request the client’s MA recipient number, the client’s eligibility for Medical Assistance, and pertinent clinical information to support the mental health or drug and alcohol diagnosis, using the DSM-IV diagnostic criteria. Please refer to the **Case Management Information Checklist** for a list of points providers should be prepared to discuss with a Care Manager when calling in for an Emergent or Urgent authorization.
- 3 If the provider and the DBH/CBH Care Manager agree on the treatment recommendation, the Care Manager will ask where the client wants to be admitted. DBH/CBH emphasizes client choice. When necessary, DBH/CBH is available to assist in the placement process. The Care Manager instructs the provider to have the admitting facility call CBH to get the authorization number once the person is admitted to the floor. When the admitting provider calls, the Care Manager will generate an authorization number and inform the provider by telephone. The number will also be forwarded by letter to the provider.

NOTE: Only one authorization number per inpatient stay is issued, except when the level of care changes during a stay.

NOTE: As CRC and emergency psychiatric evaluations do not require prior authorization, payment will not be denied, provided all authorization and billing procedures are followed.

Authorization Guidelines for Inpatient Psychiatric Treatment of the Uninsured

County Funding is used for uninsured Philadelphia residents in need of acute psychiatric services and is managed by CBH and the Office of Mental Health and Mental Retardation (OMH/MR).

- ▶ The acute inpatient level of care will be determined in accordance with Medical Necessity Criteria outlined in Appendix T of HealthChoices and the Clinical Care Guide.
- ▶ CBH will authorize placement and encourage treatment providers to enroll individuals in Medicaid, if they qualify, as soon as possible.
- ▶ Uninsured clients in need of primary drug and alcohol treatment should be referred to the Behavioral Health Special Initiative (BHSI).
- ▶ Individuals from other counties and/or states will be referred to their respective Offices of Mental Health and will not be approved for County Funding.
- ▶ Once a child or adolescent is admitted into treatment under County Funding, providers are required to conduct concurrent reviews with CBH Care Managers. Failure to do so will result in withdrawal of authorization and OMH will not reimburse for services.

OBTAINING AUTHORIZATION FOR INPATIENT HOSPITALIZATION FOR THE UNINSURED

- ▶ Provider establishes Philadelphia residency and insurance status of client through the use of the EVS. If the individual meets Medical Necessity Criteria for acute inpatient psychiatric treatment, contact the CBH Crisis Line at **(215) 413-7171** and present the individual for admission.
- ▶ CBH Care Manager verifies insurance status of the client through EVS and PROMISe.
- ▶ Once the individual is under consideration for County Funding, the Care Manager will record the assessment information ascertained by the provider and, if appropriate, authorize admission under County Funding which may be for up to 5 days for involuntary commitments. The Care Manager will also record the number of days initially authorized.
- ▶ All County Funding information is documented and retained for submission to OMH.
- ▶ For children and adolescents, the respective DBH/CBH Care Manager will conduct concurrent review with the treatment provider following the initial authorization period.
- ▶ Decisions to deny initial or concurrent stays will be reviewed through the physician review process and will be documented on the original form.
- ▶ Once the approved criteria for County Funding have been met, complete the following guidelines:
 - Verify compliance to client liability determination standards for DBH programs. The provider hospital is responsible for conducting the assessment to determine the client's and/or their legal responsible relative's ability to cover the cost of care.
 - Verify that an MA application was made on behalf of the client upon hospital admission and that DPW rejected the client's application for reasons other than excessive income,

insufficient information, or other non-medical reasons. It is the hospital staff's primary obligation to follow-up with clients regarding DPW requirements.

- If a client is determined to be financially liable, the hospital must make collection arrangements with the client. Collected funds must be deducted from any request for county reimbursement. Verification of an exhaustive collection effort must include proof that the delinquent payment was submitted to a collector and credit bureau for credit reference. Please note that County Funding will not be available to reimburse inpatient stays for individuals who have used their annual or lifetime benefits from other third parties.

Authorization Guidelines for Clients With Medicare as the Primary Carrier

When a CBH client is also covered by Medicare and meets medical necessity criteria for inpatient or residential treatment services, the provider will need to:

- ▶ Verify coverage and the number of remaining covered days prior to contacting CBH.
- ▶ Obtain an authorization number prior to billing for third-party liability payment, even if there are remaining covered days and no pre-certification is necessary. It is the preference of CBH that clinical information be presented for continuity of care purposes.
- ▶ Proceed with the pre-certification process if the member has no remaining covered days.

Authorization Guidelines for Medical Transfer to a Behavioral Health or Drug and Alcohol Setting/Unit

In situations where it is necessary to move an individual from a medical facility to an inpatient psychiatric unit or drug and alcohol inpatient unit, a psychiatric evaluation must be completed by a licensed psychiatrist prior to presenting the individual for admission.

When there is a need to move an individual from a psychiatric inpatient unit to a substance abuse treatment setting, or vice versa, the Care Manager will assist the provider in identifying other agencies within the CBH network that provide needed services. The Care Manager, in conjunction with the provider, will make referrals, taking into consideration the client's preference. The referring provider will also arrange appropriate transportation.

Guidelines for Prior Authorization of Acute Partial Hospital Treatment

Acute partial hospitalization is a non-residential hospital-based program designed for the treatment of individuals with acute psychiatric illness or acute exacerbation of chronic psychiatric illness.

It provides an array of intensive psychiatric, medical, behavioral, and developmental services to address the acuity and severity of the individual's psychiatric symptoms in situations in which hospitalization is not required. The goal of the acute partial hospital program is to increase the level of patient functioning. Its objectives include:

- ▶ Crisis stabilization and treatment of persons with serious and persistent mental illness who are currently in treatment and require more intensive services than are provided in an outpatient setting

- ▶ Client's return to the community

Psychiatric acute partial hospitalization treatment services require prior authorization by Clinical Management.

Initial authorization for acute partial can be obtained:

- 1 As a "step-down" from acute and sub-acute inpatient treatment.** Admission into acute partial will be authorized by the Care Manager conducting the concurrent review for acute/sub-acute inpatient treatment. As part of the concurrent review process, the Care Manager confirms that the client is able to step-down into that level of care, has the capacity to participate in partial hospitalization services, and has a community-based network of supports. The Care Manager will authorize the initial admission as part of the discharge plan to the next level of care.
- 2 As a "step-up" from outpatient treatment.** Individuals attending outpatient treatment who require more intensive structure may be authorized for acute partial. In these cases, services must be authorized through the CBH Crisis Response Line at **(215) 413-7171**. These cases are authorized within 24 hours from the point of the assessment.
- 3 As a direct entry into acute partial from an assessment site.** When persons are assessed and found to be in need of more structure but do not need inpatient treatment, the assessment provider should contact the CBH Crisis Response Line at **(215) 413-7171** for authorization within 24 hours from the initial assessment.

The initial authorization will be up to 10 days for adults, and 5 days for children and adolescents, if Medical Necessity Criteria (see Appendix T or the Clinical Care Guide) are met. It is anticipated that the maximum length of stay in acute partial will be 20 days. If it is determined that a client requires additional time in this level of care, a physician review will be done to determine continued medical necessity. Authorizations will be granted according to the individual needs of the client and in conjunction with the physician review and recommendations for continued stay.

Guidelines for Prior Authorization of BHRS and Residential Treatment Services

Community Residential Rehabilitation (CRR) Host Homes, Residential Continuum Treatment Facilities (RCTFs), Residential Treatment Facilities (RTFs), and Behavioral Health Rehabilitation Services (BHRS) programs have a responsibility to meet the needs of children in their care as they move through a continuum of treatment services. DBH/CBH places a priority on continuity both within and between levels of care and expects treatment providers to actively work with clinical staff and families to help children make the transition between levels of care.

These services should be therapeutically appropriate, demonstrate cultural competence and meet the individual needs of children and adolescents, whether the service is delivered in the home, school, at work or in the community.

PREPARING CHILD AND ADOLESCENT PACKETS

Below are the criteria providers must follow when preparing the packet required for authorization of BHRS, RCTF, RTF, CRR, Host Homes and Partial Hospitalization services for children and adolescents. To streamline the process of reviewing authorization requests, providers must also complete and include a copy of the **Child/Adolescent Packet Submission Cover Letter** with every packet.

COMMUNITY BEHAVIORAL HEALTH PACKET REVIEW CHECKLIST

MA-97 OR MA-325

- Requests services accurately, including an appropriate start date.
- Signed by client/guardian and prescriber. (Prescriber is the licensed psychologist or psychiatrist who completed the evaluation.)

COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION (CBE)

- Describes background data, family information, and developmental history.
- Reviews history of presenting problem, services utilized, and progress made.
- Identifies strengths.
- Considers continuum of alternative services and describes need for BHRS, RCTF, RTF, CRR, Host Homes or Partial Hospitalization services.
- Contains Mental Status Examination and specific evidence of a face-to-face interview.
- Contains 5-Axis, DSM-IV diagnoses.
- Recommends specific services.
- Performed within 60 days prior to the initiation of requested service.
- Specifies time spent by each examiner if more than one examiner was involved.

COMPREHENSIVE BIOPSYCHOSOCIAL RE-EVALUATION (CBR)

- Summarizes background data, family information, and mental health history.
- Identifies strengths.
- Discusses the impact of the interventions on the child’s current mental health status.
- Contains Mental Status Examination and specific evidence of a face-to-face interview.
- Contains 5-Axis, DSM-IV diagnoses.
- Recommends specific services.
- Performed within 60 days prior to the continuation of services.
- Specifies time spent by each examiner if more than one examiner was involved.

ADDENDUM TO COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION OR RE-EVALUATION (CBE OR CBR)

- Describes additional information since last evaluation.
- Contains 5-Axis, DSM-IV diagnoses.
- Recommends specific services.
- Contains Mental Status Examination and specific evidence of a face-to-face interview, if completed more than 45 days after the original evaluation.

PLAN OF CARE (ATTACHMENT 6 OR 7)

- Lists all services including school, community resources, DHS, etc.
- Includes specific hours and services requested.
- Dates are concurrent with start date on MA-97.

TREATMENT PLAN

- Addresses issues raised in psychiatric/psychological evaluation.
- Identifies strengths.
- Provides specific interventions to be used.
- Includes progress made on each goal (if re-authorization).
- Is signed by client/guardian and preparer.
- Is signed by DHS representative and/or juvenile probation officer, if applicable.

INTERAGENCY MEETING

- Includes a parent/guardian, behavioral health provider, child (if age 14 or older), representative of DBH/CBH, DHS (if DHS is involved), other agencies involved with the child, and school, if services provided in school.
- Provides summary of discussion, including identification of lead clinician and crisis intervention plan.
- Outlines recommendations for specific services.
- Has signatures of participants agreeing to services (not just sign-in sheet).

SERVICE COORDINATION PLAN - BHRS CASE MANAGEMENT ONLY

- Outlines client's and family's need for case management.
- Outlines specific services to be provided with time frames.
- Includes services that extend beyond completion of BHRS packet.

ATTACHMENT 8 - RESIDENTIAL TREATMENT ONLY

- Includes Interagency Team meeting documentation.
- Is signed by County and DHS, when applicable.

SCHOOL COORDINATION PLAN - BHRS ONLY

- Demonstrates school/agency coordination for classroom-based BHRS.
- Includes statement signed by principal or designee that school agrees BHRS should be provided in the school. If school disagrees, Individual Service Planning Team (ISPT) meeting must be conducted.
- Provides an additional signed statement if child changes schools during the authorized period. Provider must advise CBH of the school change and must submit a signed statement by the new principal or designee that the new school agrees that BHRS should be provided in the new school.



Reminder:

In order to develop an effective treatment plan, the following individuals are strongly encouraged to participate in the **Interagency Meeting**.

- ▶ parent/guardian
- ▶ representatives of other systems involved with the child, i.e., juvenile probation, Department of Human Services (DHS), etc.
- ▶ representatives of the School District of Philadelphia, if the child receives special education services, or if the treatment recommendations would disrupt school placement
- ▶ behavioral health treatment provider
- ▶ the child, if possible (required if age 14 or older)
- ▶ representative of DBH/CBH, when possible

NOTE: Addendums are additions or changes to a completed, comprehensive evaluation based on either the exchange of clinical information or a face-to-face meeting with the client. **Addendums are used when there is an amendment (increase, decrease or change in number or type) to current services.** Addendums **must** be accompanied by the original evaluation or the request will be deemed unacceptable and will be returned to the provider as insufficient documentation.

TIMELINES FOR AUTHORIZATION OF CHILDREN'S SERVICES

Initial requests for children's services must be submitted within 10 business days from the date that the evaluation was completed. Requests for continued BHRS, RCTF, RTF, CRR, Host Homes and partial services must be submitted no earlier than 21 calendar days and no later than 15 calendar days from the last covered day. If parent(s) miss more than three evaluation appointments, providers should contact CBH Member Services, who will provide outreach to the respective families. Contact to CBH Member Services must occur before the provider considers terminating services to the child/family.

Determining Level of Care for Adolescent Substance Abuse

To assist DBH/CBH in determining the appropriate level of care for adolescent substance abuse treatment, credentialed providers of Child/Adolescent Drug and Alcohol services must complete and submit a copy of the **Adolescent ASAM (American Society of Addictive Medicine) Summary Form**.

This form requests specific information about children and adolescents who are currently in or about to be referred to drug and alcohol treatment programs. The **Adolescent ASAM Summary Form** is used to record information on admissions, concurrent reviews and discharges/referrals. To ensure its standardized use, CBH has included the **Adolescent ASAM Summary Form** within this manual and distributed it to all applicable participating CBH providers.

Should providers of Outpatient Child and Adolescent Drug and Alcohol Services submit the Adolescent ASAM Summary Form to CBH?

NO Providers of outpatient behavioral services are no longer required to mail concurrent reviews to CBH. However, because the Adolescent ASAM Summary Form includes a section for concurrent review information, it should be completed and maintained in the client's chart.

Should Child and Adolescent Drug and Alcohol providers of more intensive levels of care, beyond outpatient services, mail the Adolescent ASAM Summary Form to CBH?

YES Providers of Child and Adolescent IOP and Residential 3b and 3c services do need to submit a copy of the Adolescent ASAM Summary Form to:
Director of Clinical Management—CBH, 801 Market Street, 7th Floor, Philadelphia, PA 19107 for review of admissions, concurrent reviews, and discharges/referrals. Additionally, a copy should be maintained in the client's chart.

Providers with questions or concerns should call CBH Provider Relations at **(215) 413-7660**.

Guidelines for Prior Authorization of Psychological Testing

Psychological Testing employs professionally recognized standardized instruments that have been determined to be useful for a variety of diagnostic and treatment planning purposes. The administration and interpretation of such instruments are regulated by their vendors, the codes of ethics of the mental health professions, and state professional licensing laws. Administration of diagnostic instruments and structured assessment tools should be consistent with all such regulations and guidelines whether the administration occurs as part of a Comprehensive Biopsychosocial Evaluation (CBE) or part of Psychological Testing. Psychological Testing typically involves the administration of a battery of instruments and/or relatively lengthy and/or specialized assessment tools over a concentrated period of time. Psychological Testing must be performed by or under the supervision of an appropriately credentialed psychologist or psychiatrist.

Psychological Testing can be requested when, after completing a CBE, the provider determines that additional diagnostic instruments and structured assessment tools are required to develop an effective case formulation and behavioral health treatment plan. It is the expectation of DBH/CBH that CBEs, complemented by additional Psychological Testing when necessary, will lead to individualized, comprehensive evaluations that determine the treatment needs of individuals. Testing results should be appended to the case formulation, and incorporated into the treatment plan if clinically indicated.

Generally, CBH will consider requests for Psychological Testing under two circumstances:

- 1 Intelligence and/or achievement testing is indicated to inform the behavioral health treatment plan.
- 2 Extended (more than 4 hours) evaluation is indicated to inform the case conceptualization and behavioral health treatment plan. The extended evaluation must utilize diagnostic instruments and structured assessment tools targeted to specific evaluation questions generated by the CBE.

Psychological Testing may also be indicated to address questions that are not primarily related to behavioral health services. Such requests should be directed to the appropriate payor.

For example:

- ▶ Requests for neuropsychological testing to determine organic contributions to behavior should be directed to the member's HMO.
- ▶ Requests in support of educational services should be directed to the member's School District.
- ▶ Requests in support of vocational services should be directed to the PA Office of Vocational Rehabilitation.

Psychological Testing requires prior authorization for reimbursement except if performed by inpatient, residential, or Juvenile Justice System (JJS) providers who have a "bundled" evaluation rate established with CBH. These providers are not eligible for consideration of additional payments for Psychological Testing.

As a medically necessary, specialized, pre-authorized service, Psychological Testing will be supported by CBH for eligible providers when:

- ▶ The requestor is under contract with CBH to provide Psychological Testing.
- ▶ The client or appropriate representative has provided informed consent for Psychological Testing.
- ▶ A legible and complete **Psychological Testing Pre-Authorization Request Form** is submitted and approved by CBH. The **Psychological Testing Pre-Authorization Request Form** should be mailed or faxed to the attention of the **Chief Medical Officer, CBH, 801 Market Street, 7th Floor, Philadelphia, PA 19107; Fax: (215) 413-7111**. The provider will be notified of approval or denial by return fax within two business days.
- ▶ The testing is performed within one month of CBH approval by a licensed psychologist or psychiatrist who participates in the client's treatment team, or an appropriately qualified and supervised non-licensed professional in accordance with Section VIII, Clinical Supervision, of the CBH Credentialing Policy and Procedures Manual.

PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUESTS WILL BE APPROVED WHEN:

- ▶ The request is in support of behavioral health services other than establishing risk for fire setting. CBH will not authorize requests primarily in support of medical/physical treatment/rehabilitation or educational/vocational services in the absence of a specific anticipated impact on the behavioral health treatment plan.
- ▶ The request for testing should describe how the additional evaluation will impact the development of an appropriate and clinically effective treatment strategy.
- ▶ The most recent CBE is appended to the request. The request documents why the CBE is insufficient to determine an appropriate behavioral health treatment plan, or why the current course of treatment is failing.
- ▶ The request indicates by name what tests will be administered, the questions that each test will address, and estimated administration time for each test. Note that estimated testing times that differ significantly from test publisher recommendations should be accompanied by a rationale.
- ▶ The request is signed by a licensed psychologist or psychiatrist and the PA license number is indicated.

A copy of the **approved Psychological Testing Pre-Authorization Request Form** should be placed in the member's clinical record along with test scoring forms, and a report of the testing results. These materials should be made available to CBH upon request.

If a request is denied, and an appeal is requested, the standard Appeals Procedure should be followed.

CBH reserves the right to retroactively disallow reimbursement for Psychological Testing should any audit find non-compliance with the procedures and criteria noted above.

Authorization Guidelines for Out-of-Plan and Out-of-Area Services

An Out-of-Network Referral is a referral made to a behavioral health care provider who does not have a contractual relationship with CBH to provide those services for which the member is being referred. These are generally services not available within the CBH provider network or for clients temporarily residing outside of Philadelphia County.

It is important to understand that while a provider may recommend that a CBH client is in need of treatment services not available in the network, only CBH can authorize treatment of a CBH client by an out-of-network provider. **CBH may refuse to pay for any out-of-network treatment services that have not been prior authorized.**

Guidelines for Obtaining Community Support Services

Providers may obtain a range of community support services on behalf of CBH clients. Unlike other CBH in-plan services, the first three community support services listed below are authorized and coordinated by the Philadelphia County Office of Mental Health (OMH). To obtain prior authorization, call **(215) 599-2150**. Crisis Residence services are authorized by CBH on behalf of its clients. Community Support Services include:

INTENSIVE CASE MANAGEMENT (ICM): ICM is for persons with a major mental illness who may also have significant substance abuse problems. ICM is recommended for persons who experience frequent hospitalizations or times of crisis. These individuals may be unable to obtain or maintain a safe place to live, or to identify, reach, and maintain personal goals. Intensive Case Managers typically meet with clients every 14 days and are available on a 24-hour basis. They generally assist clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation, and recreation.

RESOURCE COORDINATION (RC): RC is for persons with a major mental illness who may also have substance abuse problems and mild-to-moderate difficulty in social, job-related, or daily living skills. Resource Coordinators typically meet with clients once or twice a month to every other month, depending upon need, and are available during weekday business hours in the event of difficulty. They generally assist clients with obtaining and coordinating community resources, and provide training, support, and assistance with living safely in the community by helping clients maintain stable relationships, housing, and employment.

FAMILY-BASED MENTAL HEALTH SERVICES (FBMHS): The Family-Based Mental Health Program provides a variety of in-home services to children and adolescents with mental health and/or substance abuse disorders and their families. These include traditional therapy services and non-traditional services such as respite services for families, transportation, and linkage with other service systems and community resources. The program assists children who are at risk for psychiatric hospitalization or placement out of the home. It is a short-term program and provides a transition to other community-based programs.

CRISIS RESIDENCES (CR): Crisis Residences provide short-term residence options in a community setting for persons in crisis.

Services That Can Begin Without Prior Authorization but Require an Authorization Number for Payment

There are specific services that the treatment provider may begin to provide without requesting prior authorization. The provider must however, request and obtain an authorization number to receive payment for services. These include:

- ▶ all maintenance psychiatric partial hospitalization services
- ▶ all Intensive Outpatient Provider (IOP) services
- ▶ all initial and follow-up psychiatric consultations
- ▶ all Comprehensive Biopsychosocial Evaluations (CBEs) and Re-evaluations (CBRs)
- ▶ all emergency psychiatric evaluations
- ▶ all court evaluations

The provider should request an authorization number shortly after the episode of treatments begins but no later than 90 days after the date of service. CBH will acknowledge treatment approval of these services by generating an authorization number required for payment. If an authorization number is not requested prior to 90 days or an authorization number is not requested prior to submitting the claim, CBH cannot reimburse the provider.

Guidelines for Authorization of Maintenance Psychiatric Partial Hospitalization Treatment

Maintenance psychiatric partial hospitalization can begin without prior authorization; however an authorization number is required in order to receive payment. Maintenance psychiatric partial is a non-hospital based psychiatric program that provides less than 24-hour care for individuals who are stabilized post-crisis, but require more ongoing, non-acute support than is available in traditional outpatient or aftercare programs. These programs provide an array of services which includes medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental services. Unlike acute partial, the array of services are offered on a longer-term basis and are more related to psychosocial rehabilitation. Individuals often step down from an acute partial program to a maintenance partial as a natural step in the continuum of care, which assists the individual in continuing the progress made in treatment. The goal is to assist with improving the individual's level of functioning in the community.

The Program should submit the **CBH Authorization Request Form – Long-Term Partial** within 90 calendar days after the date of admission or from the start date of the new authorization period. The authorization period will be for 6 months.

Guidelines for Authorization of Intensive Outpatient (IOP) Drug and Alcohol Treatment

IOP services for substance abuse treatment can begin without prior authorization, both for admissions and continued stay, for CBH members and members of Pennsylvania's Behavioral Health Special Initiative (BHSI), which provides services for individuals who have lost or are not eligible for Medical Assistance.

IOP services are provided according to a planned regimen consisting of regularly scheduled treatment sessions 3 days per week, for 5 to 10 hours per week. IOP programs may not provide more than 3 days of IOP services per week unless approved by CBH/BHSI, nor can **the number of clinical treatment hours provided exceed 10 hours per week**. The program should submit the **CBH Intensive Outpatient (D&A) Service Request** form within 90 calendar days after the date of admission or from the start date of new authorization period. The authorization period will be for 4 months.

A person who is not eligible for Medical Assistance may begin IOP treatment under BHSI funding. If the individual is subsequently enrolled in Medical Assistance and transferred to CBH, the IOP episode will be considered one episode. Therefore, once the transfer is made, it will be designated as a "continued stay" and not a new admission. CBH will issue an authorization number for the remainder of the four month time period.

Guidelines for Authorization of Psychiatric Consultations in Medical Facilities

CBH requires that an **Initial Psychiatric Consultation and Follow-up Visits in a Medical Facility** form be completed, after conducting an initial psychiatric consultation and/or follow-up consultation, for all CBH clients in non-psychiatric hospital beds or rehab facilities (medical facilities). The forms should be mailed to the Chief Medical Officer, CBH, 801 Market Street, 7th floor, Philadelphia, PA 19107 within 90 days after the date of the consultation. **Do not submit consultation requests by telephone or fax.**

For a member in an inpatient medical setting, CBH does not require prior authorization for an initial or follow-up psychiatric consultation, as long as:

- ▶ the psychiatric consultation is requested by the attending physician responsible for the patient's care during the inpatient stay, and
- ▶ medical necessity is determined.

CBH reserves the right to retroactively deny payment if a consultation is not deemed medically necessary. The following constitutes Medical Necessity:

- ▶ suicidal ideation, intent or plan
- ▶ homicidal ideation or plan
- ▶ acute agitation
- ▶ chronic and persistent mental illness with concomitant medical illness
- ▶ substance abuse and dependence, including detoxification
- ▶ constant observation needed

- ▶ differential diagnosis and treatment recommendations are requested
- ▶ competency assessment
- ▶ any psychiatric disorder or disturbance that interferes with a patient's care in a medical setting

CBH provides payment for one initial consultation and one follow-up visit.

NOTE: Psychiatric consultations are to be performed **ONLY** by licensed psychiatrists who are independently credentialed by CBH.

Guidelines for Authorization of Comprehensive Biopsychosocial Evaluations and Re-Evaluations

Comprehensive Biopsychosocial Evaluations and Re-evaluations (CBE and CBR) are defined as a complete gathering of ecological information through client interviews, discussion with family members and/or caretakers, review of clinical records, and contact with collaborating agencies that leads to a biopsychosocial formulation, diagnoses, and treatment plan. CBEs are compensated in 30-minute units for up to eight units (4 hours) per evaluation while CBRs are compensated in 30-minute units for up to four units (2 hours) per evaluation. Providers must fully document in the client's clinical chart the date and time (in clock hours) that the CBE/CBR was completed and the specific clinical activities that occurred during each 30-minute unit. The CBE/CBR must also be legibly signed by the clinician who engaged in the clinical activities during that unit.

The request for authorization for CBE/CBR must be submitted after the evaluation has been completed and within 90 days of service provision using the **CBH Outpatient Service Request Form**. Providers must indicate the dates over which the evaluation occurred (cannot exceed 45 days), the number of units being requested, and whether a psychiatrist or a licensed psychologist conducted the evaluation by using the correct level of care code on the CBH Outpatient Service Request Form. While the CBE authorization is generated over a span of dates, each date of service must be billed on a separate claim line. If the evaluation is not completed, it cannot be billed as a CBE but could be billed as one assessment.

Services That Can Begin Without Prior Authorization and DO NOT Require an Authorization Number for Payment

There are specific services that the treatment provider may begin to provide without requesting prior authorization and can receive payment for services without an authorization number. These include:

- ▶ all outpatient mental health and drug and alcohol services, except for Psychological Testing
- ▶ all methadone maintenance clinic services
- ▶ all assessments
- ▶ Crisis Response Center (CRC) evaluations

In order to expedite payment of claims, the provider should request that the case be opened shortly after the episode of treatment begins by submitting a **Case Open Request Form**. Providers must then submit a claim within 90 days of service provision (please allow two weeks for CBH to open a case before submitting a claim for payment).

Guidelines for Extending the Authorization of Treatment Services

The process used to obtain authorization for extended or continuing treatment runs parallel to the one used to obtain the initial authorization. (See the **DBH/CBH Referral and Authorization Process Flow Chart**.) The procedure is as follows:

- ▶ **If initial treatment required prior authorization**, the provider must obtain prior authorization to proceed with extended treatment. The provider must provide the Care Manager with pertinent clinical information that justifies medical necessity for continued treatment. For drug and alcohol programs, providers are required to provide clinical information to support the six dimensions of the PCPC for continued stay.
- ▶ **If initial treatment could begin without prior authorization** but required an authorization number for payment, the provider can again begin providing extended or continuing treatment without prior authorization but must obtain an authorization number by submitting an **Outpatient Service Request Form** within 90 days of service provision.

The Care Management staff at DBH/CBH assess the appropriateness and efficacy of current, extended, and completed treatment through ongoing review. The goal is to ensure that medical necessity criteria are met, that treatment planning is appropriate given the clinical nature of the presenting problem, and that discharge planning occurs as part of the overall treatment process. Utilization review, concurrent review, and retrospective review are all components of the review process.

Discharge Standards

The process of discharge planning is essential to the provision of treatment. It ensures that all appropriate linkages to other levels of care and supportive services are made prior to a client's discharge. There are many types of discharges that can take place, all of which require careful planning and coordination in an effort to ensure, at the very least, the safety of the client (as well as staff) and the continuity of care and support. The following are types of discharges that can take place:

Successful Completion of Treatment

Client successfully completes the treatment program. This includes meeting goals and objectives identified on the treatment plan. Discharge summaries are called in to the Care Manager within 24 hours.

Medical Leave

Client is discharged to a medical facility for treatment of a medical condition requiring immediate attention. Such medical conditions may include an injury requiring emergency room intervention, delivery of an infant, or continued treatment for ongoing acute medical conditions.

Therapeutic Leave

Therapeutic leave assists women who are reuniting with their children and are making the transition from a single women's residential program to one that provides treatment to women with children. It would also benefit adolescents returning home after long-term care whose transition plans include weekend visits with the family.

Transfer to Another Level of Care

In many cases, clients may need to move to a more intensive level of care and/or a specialized level of care that will better address their treatment needs. For example, a client who may begin to present with psychiatric symptoms after being placed into a short-term residential treatment program may require a dual diagnosis program. Or, that client may move from a medically-monitored residential program to an intensive outpatient program and recovery housing.

Guidelines for Coverage of Children in Residential Treatment Programs Requiring Hospital Leave

HOSPITAL LEAVE PROCEDURES

- ▶ If the child is not in the residential treatment program overnight, the facility must inform DBH/CBH of the hospital leave within 24 hours. The facility must document and report this as a **significant incident**. (See section on Quality Management for details on reporting a significant incident.)

During the Child's Hospital Stay

During hospitalization, the RTF provider must actively coordinate all activities related to the treatment of the child. Coordination activities must include the hospital and the DBH/CBH Care Manager and must be documented in the child's case record at the residential treatment program. When the child is readmitted to the residential treatment program, the facility must develop a new residential service treatment plan that reflects the child's recent hospitalization.

Prior to the Child's Hospital Discharge

- ▶ If the residential treatment services continue to be clinically appropriate for the child upon discharge from the hospital, the residential treatment program must take the child back immediately upon discharge from the hospital.
- ▶ The discharging facility's treating physician or psychiatrist must prepare and submit to the residential treatment program a comprehensive evaluation that includes a recommendation that the child return to the residential treatment program for the balance of the original approved period.
- ▶ DBH/CBH will review the clinical information during the hospital stay. If it is determined that the child's return to the residential treatment program is unlikely, the residential treatment program will be notified and an end date will be determined.

REIMBURSEMENT ISSUES

- ▶ In order to reserve a child's residential treatment program bed when the child leaves for either a general inpatient hospital or a psychiatric facility, CBH will reimburse at one-third (1/3) of the facility's negotiated per diem rate for up to 15 days per calendar year.
- ▶ For this period, the residential treatment program may not accept reimbursement from any other source on behalf of the child.
- ▶ The days during a **hospital leave** can be billed **electronically** or **on paper** and **separately** from the residential treatment billing. The residential treatment program should calculate the units to be **one-third (1/3) of the unit** (not one-third of the rate) for **each** day in the hospital. Providers who use the UB-92 claims forms, should show only the one-third (1/3) calculated units in the Service Units field (Box 46). The hospital stay will be recorded by CBH and used for compliance purposes.
- ▶ The residential treatment program will be reimbursed for less than 15 days if, during the hospital leave, CBH determines that it would not be clinically beneficial for the child to return to the residential treatment program.

Against Medical or Facility Advice (AMA) or Absent Without Leave (AWOL)

A client may choose to terminate treatment voluntarily despite recommendations for ongoing care and intervention efforts by the treatment program staff, Care Management, and CBH Member Services.

When an DBH/CBH client (whether an adult or child) leaves an inpatient or residential mental health or drug and alcohol treatment facility Against Medical Advice (AMA), or is Absent Without

Leave (AWOL), it should be reported as a **significant incident**. (See section on Quality Management for details on reporting a significant incident.)

Providers must report all significant incidents through a centralized, two-step reporting process. This process covers all DBH/CBH clients receiving in-plan services, as well as those receiving supplemental funding through DBH/CBH.

Providers must take BOTH of the following steps in the event of a AWOL or AMA incident:

1 Report the incident by phone within 24 hours to the CBH Crisis Line **(215) 413-7171**

AND

2 Fax a completed copy of the Significant Incident Report Form within 72 hours (within 24 hours in the event of death or abuse) to DBH/CBH Quality Management at **(215) 413-7132**.

A more detailed outline of this process is contained in the Quality Management section of this manual.

Guidelines for Coverage of Children in Residential Treatment Programs who are Absent Without Leave (AWOL)

Upon discovery that the child is missing, the facility must:

- ▶ conduct an extensive search of the facility buildings, grounds, and off-site areas
- ▶ file a missing persons report with the police
- ▶ notify DBH/CBH
- ▶ notify either the Department of Human Services (DHS) if the child is in its custody or the child's responsible family member and/or legal guardian

REPORTING THE INCIDENT AND DOCUMENTATION

- ▶ When the child is found or returns, the facility must notify all previously notified parties that the child is no longer missing.
- ▶ Each of the above-listed activities must be documented in the child's record.
- ▶ Each notation in the record must be signed and dated upon entry and must give a date, time, and summary of each action taken.
- ▶ Documentation of on-site and off-site searches must specify the date and hours of search, where the search was conducted, any pertinent findings, the date and time of the child's return, and must be signed by staff who conducted the search.

REIMBURSEMENT ISSUES

- ▶ If a child is AWOL, payment will be made by CBH for up to 48 hours that the child is absent **only** if the provider documents in the child's record all attempts that the provider made to locate the child. An absence less than 48 hours will not be compensated if the required reporting does not occur during the above required time frames. The provider will be compensated at the same per diem rate already negotiated with the facility.

- ▶ AWOLs in excess of 48 hours are not compensated and must not be shown as covered days on a claim to the CBH. It is expected that a youth will be readmitted to the facility after a return from an AWOL even if the time away from the facility exceeds 48 hours.

Guidelines for Coverage of Clients in Inpatient Drug and Alcohol Residential Rehabilitation Beds

HOSPITAL LEAVE PROCEDURES

- ▶ The DBH/CBH Care Manager assigned to the non-hospital treatment program will review the clinical information during the client's hospital stay. This will be completed with the treatment program staff member responsible for coordinating care while the client is in the general hospital or a psychiatric facility.
- ▶ During hospitalization, the residential rehabilitation provider must actively coordinate all activities related to the treatment of the client. Coordination activities must include the hospital and the DBH/CBH Care Manager and must be documented in the client's case record at the residential rehabilitation facility.
- ▶ If residential rehabilitation services continue to be clinically appropriate for the client upon discharge from the hospital, the facility must take the client back immediately upon discharge.
- ▶ If the DBH/CBH Care Manager decides that the client's return to the residential rehabilitation is unlikely, the residential rehabilitation facility will be notified and an end date will be provided for billing purposes.
- ▶ The discharging facility's treating physician or psychiatrist must prepare and submit to the residential rehabilitation facility a summary of the treatment and medications provided to the client (if applicable).
- ▶ A drug and alcohol (D&A) assessment is not required for re-entry into the program.
- ▶ When the client is readmitted to the residential rehabilitation facility, the facility must revise the treatment plan to reflect the hospitalization and to identify any changes in goals and objectives. The DBH/CBH Care Manager will record this as part of the continued stay review with the respective substance abuse treatment program.
- ▶ If the client is not in the residential rehabilitation overnight, the facility must inform DBH/CBH of the hospital leave within 24 hours. The facility must document and report this as a **significant incident**. (See section on Quality Management for details on reporting a significant incident.)

REIMBURSEMENT ISSUES

- ▶ In order to reserve a client's non-hospital D&A residential bed when the client enters either a general inpatient hospital or a psychiatric facility, DBH/CBH will reimburse the inpatient non-hospital treatment providers at one-third (1/3) of the facility's negotiated per diem rate for up to 15 days per calendar year.
- ▶ For this period, the D&A facility may not accept reimbursement from any other source on behalf of the client.

- ▶ The residential rehabilitation facility will be reimbursed for less than 15 days if, during the hospital leave, DBH/CBH determines that it would not be clinically beneficial for the client to return to the residential rehabilitation placement.
- ▶ The days during a **hospital leave** can be billed **electronically** or **on paper** and **separately** from the residential rehabilitation treatment billing. The residential rehabilitation facility should calculate the units to be **one-third (1/3) of the unit** (not one-third of the rate) for **each** day in the hospital. The hospital stay will be recorded by DBH/CBH and used for compliance purposes.

Involuntary Discharge

On occasion, clients are involuntarily discharged from services prior to completion of treatment for a number of reasons including non-participation in treatment, lack of therapeutic alliance, or behavioral problems that may threaten the physical safety of staff or other clients. In some cases, those involuntary discharges may have been prevented or issues resolved with appropriate interventions and/or alternative options.

DBH/CBH POLICY REQUIREMENTS REGARDING INVOLUNTARY DISCHARGE

DBH/CBH is committed to fostering a consumer-focused system of care with the goal of providing behavioral health services most appropriate to meet our client's needs. DBH/CBH staff work to ensure that all clients have access to behavioral health services and that there is continuity of care between:

- ▶ levels of treatment
- ▶ levels of supplemental benefits
- ▶ treatment and transition to the community

State requirements mandate licensed treatment providers to review involuntary discharge criteria with clients upon admission into treatment. DBH/CBH in no way condones or supports the involuntary discharge of members without options or interventions being offered to the member. DBH/CBH treatment provider must not conduct involuntary discharge proceedings without the involvement, consultation and review by a team that includes:

- ▶ the treatment provider
- ▶ medical director of the treatment facility
- ▶ CBH
- ▶ OMH/MR
- ▶ CODAAP, including BHSI

This policy of consultation regarding involuntary discharge applies to both in-plan services offered by CBH and supplemental benefits made available through OMH/MR and CODAAP. In-plan services are defined as psychiatric inpatient and outpatient treatment, partial hospitalization, the continuum of substance abuse treatment, children's services, and intensive case management. Supplemental benefits include those services provided through OMH/MR and CODAAP, including but not limited to recovery housing, supportive housing, etc.

It is expected that during the course of treatment and through the authorization process, there is ongoing dialogue between the respective DBH/CBH administrative units including:

- ▶ DBH/CBH Care Manager
- ▶ CBH Member Service Representative
- ▶ OMH/MR—Targeted Case Management Unit
- ▶ OMH/MR—Access to Alternative Services (AAS)
- ▶ Behavioral Health Special Initiative (BHSI)
- ▶ Quality Management Units of DBH

The respective DBH/CBH staff will be involved in defining interventions, alternative options and/or other resolutions that may facilitate continued treatment in the current setting or in an alternative setting. This policy applies to all clients who are active in and attending treatment within DBH/CBH, including those who are Medicaid-eligible and those who are non-Medicaid eligible. The respective staff, such as Member Services, Care Managers, Targeted Case Managers (OMH/MR and BHSI), and OMH/MR Housing Staff are to intervene, when appropriate, at the point that an involuntary as well as voluntary discharge is being considered.

INVOLUNTARY DISCHARGE PROCEDURES

Involuntary Discharges are classified as significant incidents. If an DBH/CBH client, whether an adult or child, is involuntarily discharged from an inpatient or residential mental health or D&A facility, providers must follow the procedures for reporting significant incidents. This procedure is described in the Quality Management section of this manual.

This centralized, two-step reporting process applies to all DBH/CBH clients—those receiving in-plan services, as well as those receiving supplemental funding through the OMH/MR and CODAAP, including BHSI.

In the event of an Involuntary Discharge, providers must take BOTH of the following steps:

- 1 Report the Involuntary Discharge by phone within 24 hours** to the Director of Clinical Management at CBH, **(215) 413-3100**. The purpose of this call is to discuss why involuntary discharge is being considered, to facilitate communication with member/family, and to begin advocacy efforts. The Director of Clinical Management will involve other staff within DBH, as indicated. (In the event that the discharge occurs over a weekend, call the CBH **Crisis Line** at **(215) 413-7171**.)

AND

- 2 Fax a copy of the Significant Incident Report Form within 72 hours** (within 24 hours in the event of death or abuse) to Quality Management at **(215) 413-7132**.

NOTE: For persons who are court-mandated to treatment, the treatment program has the responsibility for requesting court intervention whenever there is a lack of client compliance. The treatment program must notify the court prior to any planned involuntary discharge or at the time of an unanticipated involuntary discharge.

Resolving Disagreements about Treatment Recommendations

If the provider and the DBH/CBH Care Manager do not agree about the level of care or intensity of treatment, the Care Manager will initiate further discussion of the client's needs, presenting symptoms, and the rationale for treatment. If they can then come to an agreement, the agreed upon treatment recommendations will stand.

If an agreement cannot be reached, the Care Manager will present the case to an DBH/CBH Physician Adviser. If the DBH/CBH Physician agrees with the provider's recommendation, the DBH/CBH Care Manager will call the provider and continue the authorization process.

If the DBH/CBH Physician does not agree with the provider, the DBH/CBH Care Manager will inform the provider of the DBH/CBH Physician's recommendation. If the provider agrees with that recommendation, the authorization process resumes. If there is still no agreement, the provider's Attending Physician may request a peer review. Appropriate physician names and phone numbers will be shared at this time. If the physicians come to an agreement, they will inform their respective staff and the process will resume.

If the provider is still not satisfied with the treatment decision, a denial letter will be generated.

Clinical Appeals Procedure

Appeals can occur at three levels. **All appeals must be submitted in writing.**

FIRST LEVEL APPEALS: CBH APPEALS COORDINATOR

- ▶ The provider submits the complete medical record or the BHRS/residential treatment packet for the episode of care in question, along with a statement indicating the wish to appeal the decision, to the CBH Appeals Coordinator. This first level appeal of authorization decision must be submitted no more than 90 days after the end of the episode of care in question.

NOTE: Provider timelines for submission of appeals of authorization decisions will not apply to clients admitted under County Funding whose coverage later converts to CBH.

- ▶ The Appeals Coordinator reviews the case and, if authorization is clearly warranted, will issue the authorization.
- ▶ If the clinical necessity or administrative appropriateness of the care is in question, the Appeals Coordinator forwards the case to an DBH/CBH Physician for review and decision.
- ▶ The DBH/CBH Physician's decision, if not in agreement with the recommendation of the Appeals Coordinator, supersedes the Appeals Coordinator's recommendation in all cases.
- ▶ CBH will notify providers of the result of their first level appeal within 30 days of the receipt of the appeal request.

SECOND LEVEL APPEAL: CBH CHIEF MEDICAL OFFICER

- ▶ In the event the provider disagrees with the appeal decision, the provider may request a second level appeal. Second level appeals should be addressed to the CBH Chief Medical Officer in writing, along with any additional documentation not provided at the time of first level appeals, no more than 30 days from the receipt of notification of the results of first level appeals.
- ▶ The CBH Chief Medical Officer or designee will review the second level appeal and inform the provider of the decision in writing no more than 30 days from the receipt of the second level appeal. If for any reason the CBH Chief Medical Officer was involved in ongoing review or first level appeal review of the case in question, another previously uninvolved DBH/CBH Physician will conduct the second level appeal review.

THIRD LEVEL APPEAL: OMH/MR MEDICAL DIRECTOR

- ▶ Should the provider disagree with the second level appeal decision, the provider may submit a request for a third level appeal. The request for a third level appeal should be directed in writing, along with any additional documentation, to the Medical Director, OHM/MR, no more than 30 days after the receipt of notification of the results of the second level appeal.
- ▶ Third level appeals may be reviewed by the OMH/MR Medical Director or by physicians outside CBH who serve on a panel convened for such purposes (impartiality being the rationale for the panel's existence).
- ▶ The provider is notified, in writing, of the results of the third level appeal within 15 days of the receipt of the third level appeal.
- ▶ The decision of the third-level reviewer is final.

Denial of Services Notification

CBH clients requesting or receiving services will be notified in writing when services have been denied so that they may have the right to appeal the decision. If Medical Necessity Criteria are not established or met during the initial pre-certification or concurrent review process, and a denial of services is deemed appropriate by the DBH/CBH Physician Advisor, a denial letter is faxed to the client at the facility. Reasons for the denial of requested services will be stated in the letter as well as instructions on the appeals process.

- ▶ For all levels of care, with the exception of BHRS and residential treatment services, denial letters are faxed to the provider who is responsible for giving the CBH client the denial letter.
- ▶ The provider is expected to document clearly in the chart that the denial letter was given to the CBH client. The documentation must include date and time of receipt.
- ▶ It is expected that the provider will assist the CBH client in appealing the decision, with the written consent of the client, if the client so desires. This is not intended to assist providers in appealing decisions based on reimbursement, but to provide CBH clients the right to appeal decisions that further deny treatment.
- ▶ For denials of BHRS and residential treatment services, letters are mailed directly to the client and family, and a notification of denial of services is sent to providers.

FIRST LEVEL APPEALS

- ▶ If a CBH client chooses to appeal the decision, the current authorization will stand until an appeal takes place. A client's treatment will not be disrupted. Chief Medical Officer of CBH or designee will review the request for an expedited review and issue a decision within 24 hours. The provider will ensure that there is no disruption in or change to the level of service being provided to the client while the case is being appealed.
- ▶ In the event that the level of care is denied after the appeal process, DBH/CBH and the provider will work to ensure that there is an appropriate discharge plan in place prior to the client's discharge from the facility.

SECOND LEVEL APPEALS

- ▶ CBH Chief Medical Officer or designee will review the case and issue a decision within 24 hours of the request. The CBH Chief Medical Officer or designee will enter a note into the CBH Information System documenting the date, time, and outcome of the **expedited reconsideration** review.
- ▶ CBH Chief Medical Officer or designee will inform the Care Manager of the results of the expedited reconsideration review. The Care Manager will enter the authorization information consistent with the result of the review, if applicable, and inform the provider.
- ▶ When the request for an expedited reconsideration review occurs after business hours, the Care Manager will contact the DBH/CBH Physician Adviser on call for that day and present the clinical information. The Care Manager will give the DBH/CBH Physician Adviser all information needed to contact the provider directly to review the request.
- ▶ In the event that the DBH/CBH Physician Adviser on call has made the decision to deny the client's request, the Care Manager will refer the request for expedited reconsideration review to the administrative physician on call and follow the above procedures.

THIRD LEVEL APPEALS

- ▶ In the event that a client continues to disagree with the results of the expedited reconsideration review, the case will be referred to the Medical Director of the OMH/MR, with a copy to the Chief Medical Officer of CBH for a third level review. When such requests occur outside of OMH/CBH business hours, the Care Manager will page the OMH/MR Medical Director and review the information.
- ▶ The OMH/MR Medical Director or the CBH Chief Medical Officer will be provided with the information needed to contact the provider to discuss the reconsideration request.
- ▶ The OMH/MR Medical Director and/or the CBH Chief Medical Officer will inform the Care Manager of the date, time, and outcome of the third level reconsideration review. The Care Manager will document the information into the client database along with the authorization information consistent with the second level review decision. This process will also be completed within 24 hours of the receipt of the second appeal.

Resolving Disagreements about Authorizations

Authorization by CBH for in plan behavioral health services takes place in two broad categories: services that require prior approval and an authorization number to begin services and services which do not require prior approval but require an authorization number for billing. There are other services that do not require prior approval or an authorization number in order to bill. (Please see page 3.2 for a listing of services).

Procedure for Services that Require Prior Approval

For services that require prior approval, the provider must contact the assigned Care Manager to resolve any discrepancies no more than 90 days after the date of service. If an agreement cannot be reached between the Care Manager and the provider, the provider must submit a **CBH Authorization Correction Form** to the Director of Clinical Management if the request is being made within 120 days after the date of service or to the Appeals Coordinator if the request is beyond 120 days from the date of service. The Request for Authorization Correction Form must be accompanied by a cover letter that details the nature of the authorization error and the attempts made to get the authorization corrected. The provider will receive a written decision within four weeks of the date of submission of request. Any Authorization Correction Forms that are incorrectly completed or illegible will be sent back to the provider without a review.

Procedure for Services that Do Not Require Prior Approval but Require an Authorization Number

For services that do not require prior approval but require an authorization number for payment, the provider must submit a **CBH Authorization Correction Form** to the Data Entry Supervisor within 90 days of the date of service. Providers will receive the corrected authorization number via an Authorization Letter or Report within four weeks of the date of submission. In the event that an authorization number cannot be corrected as requested, the provider will receive a CBH Outpatient Feedback Form notifying the provider of such.

Request for authorizations that are more than 90 days after the date of service must be submitted to the Operations Coordinator. The request must contain the CBH Authorization Correction Form and a cover letter that details the nature of the authorization error, the attempts made to get the authorization corrected and the reason the request is being submitted past 90 days. The provider will receive a written decision within four weeks of the date of submission of request. Any Authorization Correction Forms that are incorrectly completed or illegible will be sent back to the provider without review.

Procedure for Targeted Case Management and Family-Based Services

Questions regarding authorizations for targeted case management or family-based services should be directed to the Office of Mental Health.

Living Arrangement, Vocational/Educational and Priority Group Codes

All Case Open and Service Request Forms must contain all requested information, including living arrangement, vocational/educational and priority group codes. Forms that do not contain this information will be returned to the provider for completion of any missing or illegible items and delays in this process will not be grounds for late submission appeals.

LIVING ARRANGEMENT CODES

Enter the appropriate number below in the Living Arrangement column of the CBH Case Open, Outpatient, Adult Partial or IOP Service Request Forms.

CLIENT INDEPENDENCE OF LIVING STATUS			
70	Living Independently	74	Restrictive Setting
71	Family Setting	75	Homeless
72	Living Dependently	99	Unknown
73	Supervised Setting		

VOCATIONAL/EDUCATIONAL CODES

Enter the appropriate number below in the Vocational Education column of the CBH Case Open, Outpatient, Adult Partial or IOP Service Request Forms.

CLIENT VOCATIONAL/EDUCATIONAL STATUS			
70	Competitive Employment	74	No Activity
71	Training/Education	99	Unknown
72	Work Program		
73	Meaningful Activity		

PRIORITY GROUP CODES

There are 14 different Priority Groups and a member can have more than one. The Priority Group Codes from which you can choose are as follows:

- ▶ **Adult Mental Health** (Codes: 3, 4, 5, 98 and 99)
- ▶ **Child & Adolescent Mental Health** (Codes 54, 55, 56, 98 and 99)
- ▶ **Drug & Alcohol** (Codes: 60, 61, 62, 63, 64 and 65)

Code	ADULT MENTAL HEALTH
3	ADULT TARGET POPULATION #1: Involuntarily committed anytime in the last year OR a Dx in range of 295.xx, 296.xx, 298.9x or 301.83 AND any of the following:
	Current residence in or discharge from a state mental hospital within last 2 years
	Two admissions to community inpatient psychiatric units or correctional inpatient units or residential services totaling 20 or more days in the last 2 years
	Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years
	1 or more years of continuous attendance in a community MH service (at least 1 unit per quarter)
	History of sporadic treatment—at least 3 missed appointments within the last 6 months, unwillingness to maintain meds regimen or involuntary commitment to OP treatment
	One or more years of treatment for mental illness provided by a Primary Care Provider or other non-MH agency clinician within the last 2 years
	Psychoactive substance use disorder
	Mental Retardation
	HIV/AIDS
	Sensory, developmental and/or physical disability
	Homelessness (sleeping in shelters, cars, parks, abandoned buildings, etc.)
	Release from criminal detention such as jail diversion, expiration of sentence or parole, probation or Accelerated Rehabilitation Decision (ARD)
	GAF below 51
4	ADULT TARGET POPULATION #2: Diagnosis: Any diagnosable mental disorder, except the DSM “V” codes, substance abuse disorders and developmental disorders unless they occur with other serious mental illness
	Functional Impairment: difficulties with basic ADL skills, instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed meds, and functioning in social, family and vocational/educational contexts.
5	ADULT TARGET POPULATION #3: Adults who are statutorily eligible for publicly-funded MH services, but do not meet the criteria for Target Groups 1 or 2.
98	NONE OF ABOVE, BUT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet the above MH target group criteria, but are receiving MH services.
99	NOT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet the above MH target group criteria, and are not receiving MH services.

PRIORITY GROUP CODES (continued)

Code	CHILD AND ADOLESCENT MENTAL HEALTH
54	CHILD & ADOLESCENT TARGET POPULATION #1: Involuntarily committed anytime in the last year OR MUST MEET ALL OF THE FOLLOWING CRITERIA: Age <18 (or <22, if in Special Ed) AND Within the last year has had a DSM Dx (except MR or psychoactive substance use disorder) AND Receive services from any of the following: • MR • Children and Youth • Special Ed • Juvenile Justice • Health (the child has a chronic health condition requiring treatment) AND Identified as needing MH services by an interagency team, e.g. CASSP committee, Cordero Workgroup
55	CHILD & ADOLESCENT TARGET POPULATION #2: Children at risk of developing a serious emotional disturbance by virtue of any of the following: A parent's serious mental illness OR Physical or sexual abuse OR Drug dependency OR Homelessness OR Referral to the Student Assistance Programs
56	CHILD & ADOLESCENT TARGET POPULATION #3: Children and Adolescents who have had a diagnosable mental illness in the last year (excluding MR, D & A or "V" codes) that resulted in a functional impairment substantially limiting the child's role in family, school or community functioning and who did not meet the criteria for Groups 54 or 55.
98	NONE OF ABOVE BUT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet any of the above MH target group criteria, but are receiving MH services.
99	NOT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet the above MH target group criteria, and are not receiving MH services.

Code	DRUG AND ALCOHOL
60	D & A—PREGNANT WOMEN AND WOMEN WITH CHILDREN
61	D & A—INTRAVENOUS DRUG USERS
62	D & A—CHILDREN & ADOLESCENTS YOUNGER THAN 18
63	D & A—THOSE WITH SEVERE MEDICAL CONDITIONS (AIDS, TB, ETC.)
64	D & A—NONE OF THE ABOVE, BUT RECEIVING D & A SERVICES: Use this for members involved in the D&A system who do not meet any of the above D & A target group criteria, but receive D & A services.
65	D & A—NOT RECEIVING D & A SERVICES: Use this for members involved in the D & A system who do not meet any of the above D & A target group criteria, and do not receive D & A services.

SAMPLE DBH/CBH AUTHORIZATION LETTER

Department of Behavioral Health / Community Behavioral Health

AUTHORIZATION LETTER

Date

Provider Name and Address

CBH Assigned Provider ID#

Attention:

Please be advised that today the following services have been authorized for treatment based upon clinical information presented.

Client Name: Name of Client

Client CIS #: Medical Assistance Ten (10) Digit Number

Level of Care: Type and Category of Service

Units: Number of Services Approved for the Specified Period of Time

Authorized Date: Date Authorization Period Begins

Expiration Date: Date Authorization Period Ends

Authorization Number: Number Attached to the Authorization

The provider will contact the assigned Service Manager if additional services are needed. Contact will be on or before the expiration of the previously assigned length of stay. Please notify DBH/CBH if a member has been discharged prior to the date of next review. Thank you.

Sincerely,

Chief Medical Officer

BEHAVIORAL HEALTH REHABILITATIVE SERVICES PACKET SUBMISSION COVER LETTER

CHILD/ADOLESCENT

Date: _____

To: **CBH Clinical Management – BHRS Team**

From: Contact Person _____

Agency _____ CBH Provider # _____

Phone _____ Fax _____

Fax _____

Re: Child/Adolescent Name _____

MA Number _____

DHS: Custody Supervision Name of Worker _____**Type of packet** (please check): Behavioral Health Rehabilitative Services Partial Hospitalization Other (specify): After School and Weekend Program Partial Hospitalization _____

Time Period Requested: _____

Date Interagency Meeting was Held: _____

Type of Evaluation: CBE-MD CBE-Non MD CBR-MD CBR-Non MD Addendum

Name of School Child Attends _____

Address of School _____

Contact _____ Telephone Number _____

Comments: _____

RESIDENTIAL TREATMENT FACILITY PACKET SUBMISSION COVER LETTER

CHILD/ADOLESCENT

Date: _____

To: **CBH Clinical Management – RTF Team**

From: Contact Person _____

Agency _____ CBH Provider # _____

Phone _____ Fax _____

Fax _____

Re: Child/Adolescent Name _____

MA Number _____

DHS Custody Supervision Name of Worker _____

Type of packet (please check):

 Residential Treatment Facility Accredited Non-Accredited Room and Board and Treatment Treatment Only Host Homes/CRR

Time Period Requested: _____

Date Interagency Meeting was Held: _____

Type of Evaluation

 CBE-MD CBE-Non MD CBR-MD CBR-Non MD Addendum

Comments: _____

ADOLESCENT ASAM SUMMARY FORM

Please be as thorough as possible when completing these forms. Thank you.

Date _____ Client DOB _____ Age _____

Provider _____ Provider # _____

Therapist _____ Telephone _____

Client name _____ SS# _____

CIS# _____ Start date _____

Check one: Admission Continued stay Discharge/Referral

I. DSM IV Codes

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Client's Substance Abuse History (for initial assessment only)

Substance	Age of First Use	Amount/Method	Frequency of Use	Date of Last Use

II. Adolescent ASAM Assessment

1. Please describe any acute symptoms of intoxication or withdrawal that are present. _____

2. Please list client's current medical problems and prescribed medications. Also include information on recent hospitalizations.

3. Please describe the client's emotional and behavioral condition. Please include information on previous psychiatric treatment.

4. Please describe the client's level of acceptance/resistance to treatment. What are the client's motivational factors?

5. Please describe the client's potential for relapse/continued use. What is the client's understanding of relapse? How has the client responded to relapse prevention training? _____

6. Please describe the client's home environment in terms of support for recovery. Please include information on client's social support system. _____

III. Family Behavioral Health History

Please check the type of issues found in patient's family history: D/A MH MR N/A

Please describe the family's mental health and substance abuse history. _____

IV. School: Last grade completed: _____

Please describe education background. Include information on type of school attended and performance/grades.

V. DHS Involvement: DHS involvement: Yes No

DHS worker _____ Telephone _____

VI. Residence: With family Foster Care RTF Alone Other _____

VII: Treatment Recommendations: Please check one.

- LEVEL 0.5 Early Intervention
- LEVEL 1 Outpatient Treatment
- LEVEL 2 Intensive Outpatient Treatment
- LEVEL 3A Medically Monitored Inpatient Detox
- LEVEL 3B Medically Monitored Inpatient Short-term Residential
- LEVEL 3C Medically Monitored Inpatient Long-term Residential

Assessor Signature _____

Date _____

PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUEST*(Please print legibly/type)*

Member Name _____ Date of Request _____

MA CIS # _____ Date of Birth _____ Special Ed.? Yes No

Agency name _____ CBH provider # _____ Fax# _____

Requester name* _____ Position/Title _____ Phone# _____

Tester name* _____ Position/Title _____ Phone# _____

If requester and tester are different people, they must confer prior to submission of this request and both must have direct input to the treatment team.*Service code? EPSDT/Family Based (400) Non-EPSDT Mental Health (300) Drug & Alcohol (350)Diagnoses** (give complete diagnostic category name including specifiers, if relevant):

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

1. What behavioral health treatment questions will testing address?

2. How will testing impact the treatment plan for this member (be specific about services that will be considered for addition or removal from the treatment package)?

3. What other means (e.g. psychosocial, psychological, and psychiatric evaluations) have been used to answer the above testing questions and why have interviews, observations and record reviews been insufficient to yield an appropriate case formulation and treatment plan for this member at this time?

INITIAL PSYCHIATRIC CONSULTATION AND FOLLOW-UP VISITS IN A MEDICAL FACILITY

Mail this form to: Chief Medical Officer, CBH, 801 Market St. 7th Floor, Philadelphia, PA 19107

Hospital Name _____ Member's Name _____

Psychiatrist's Name _____ Member's Date of Birth _____

Psychiatrist's Tel. _____ Member's CIS # (Pt's MA#) _____

Referring Physician's Name & Tel. _____

Member's SS # _____ CBH Provider # _____ Admission Date _____

Date of Consultation: Initial Consult _____ Follow-Up Consult _____

Reason for Consultation: _____

Diagnostic/findings:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Follow-up care: While inpatient med/surg. Psych hospital _____ Drug & alcohol

(SPECIFY TYPE)

Outpatient Partial _____ Other _____ No Follow-Up

(SPECIFY TYPE)

(SPECIFY TYPE)

Note: Please indicate specific provider _____

Initial recommendation (include specific psychosocial and pharmacologic interventions): _____

CBH INTERNAL USE ONLY

Approved Date _____ Needs Further Action LOC _____

CBH Auth# _____ Date Auth'd _____ Service Manager _____

Comments: _____

SIGNIFICANT INCIDENT REPORT**Fax to Department of Behavioral Health at (215) 413-7132 within 24 hours**

Type of Service: Adult-Mental Health Adult-Substance Abuse Children's
Location of Incident: DBH Residential Outpatient Inpatient PHP Other Day Program
 Other (describe): _____

Consumer Name _____ DOB _____ SS# _____

Consumer Address _____

Date of Incident _____ Time _____ am pm

Location where incident occurred _____

Reporting Agency _____ Agency Provider Number _____

Agency/Program where incident occurred (if other than above) _____

Name, Title, Address, Phone # of person filing report _____

_____ Other Witnesses _____

Indicate Type of Incident (Please Check) *MH only

- | | |
|---|---|
| <input type="checkbox"/> Death | <input type="checkbox"/> Neglect resulting in serious injury or hospital treatment* |
| <input type="checkbox"/> Homicide committed by consumer/client within 3 months of service | <input type="checkbox"/> Arrest for criminal activity |
| <input type="checkbox"/> Suicide attempt requiring medical intervention | <input type="checkbox"/> Fire or serious property damage at a BHS service site |
| <input type="checkbox"/> Violent act by or to a consumer/client requiring emergency medical treatment* | <input type="checkbox"/> Infectious disease outbreak at a BHS provider site |
| <input type="checkbox"/> Alleged or suspected abuse (physical, sexual, financial) of or by a consumer/client* | <input type="checkbox"/> Missing person: child who has not returned home within 8 hours; at-risk adult who has not returned home within 24 hours |
| <input type="checkbox"/> Adverse reaction to medication administered by a provider that requires medical attention* | <input type="checkbox"/> Admin./Involuntary discharge or left AMA or AFA from inpatient, residential rehab. (D&A), children's residence, detox or methadone maintenance |

Summarize the incident. Include precipitating factors, current status, and description of any injuries, medical condition, if applicable

Describe any corrective actions taken to prevent occurrence _____

Pending Investigation? Yes No All pending investigations should be completed & reported within 30 days of event.

Which of the following persons were notified by telephone? Please list name and phone number of persons notified.

Psychiatrist _____ Police _____

Family/Significant Other _____ Fire Dept. _____

Community Treatment Team _____ DHS CHILdline _____

Mental Health Delegates _____ BHSI _____

CASE MANAGER ICM RC D&A _____

Other Agency _____

Signature of person filing report: _____ Date: _____

