Child and Adolescent Mental Health Rehabilitation Treatment Request Form

AmeriHealth Caritas Louisiana

Please print clearly. Incomplete or illegible forms will delay processing. Please return the completed form to AmeriHealth Caritas Louisiana's Behavioral Health Utilization Management (BHUM) team at **1-855-301-5356**. For assistance, please call **1-855-285-7466**.

Member information

Patient name:	Legal guardian:
Member date of birth:	Medicaid/health plan #:
Last authorization # (if applicable):	
Is the member currently in coordinated system of care (CSoC)? ☐ Yes ☐ No	

Provider information

Provider name:	☐ In network ☐ Out of network ☐ In credentialing process
Group/agency name: Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LAC ☐ NP ☐ Other, please specify:	
Physical address:	
Phone number:	Fax number:
Medicaid/provider/NPI #:	Contact name:

DSM diagnosis

Primary Dx:	Secondary Dx:	Medical Dx:
Please also include the ICD-10 diagnosis code along with DSM code. If the member has a substance use and/or HIV diagnosis, has a consent to release information for these related conditions been obtained? ☐ Yes ☐ No ☐ N/A		

Primary care physician (PCP) information and collaboration

Has information been shared with the PCP or other providers regarding:

The initial evaluation and treatment plan? ☐ Yes ☐ No

The updated evaluation and treatment plan? ☐ Yes ☐ No

Other behavioral health provider name and date last notified:

If no, please explain:

	1 None	2 Low	3 Moderate	4 High	5 Extreme
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/violent	☐	☐	☐	☐	☐

Medications

Is member prescribed medications? ☐ Yes ☐ No Prescribing physician(s) name(s):

Is member compliant with medications? ☐ Yes ☐ No

Please list medications and dosages:

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

CALOCUS/CASII: Date of completion:	LMHP name with credentials:

Treatment request (please check services being requested)

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

Service code: Number of units: per week

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

Service code: Number of units: per week

☐ **Home builders (HB):** Provides youth from birth through 18 years old intensive in-home cognitive behavioral therapy through family therapy and parent training. Youth are at risk of out-of-home placement, returning from out-of-home placement, or have serious behavior problems at home and school.

Service code: Number of units: per week

☐ **Multi-systemic therapy (MST):** Provides youth from 12 through 17 years old intensive home-, family-, and community-based therapy. Youth are at risk of out-of-home placement or are returning from out-of-home placement.

Service code: Number of units: per week

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

Service code: Number of units: per week

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

PSR individual in the office number of units per week:

PSR individual in the community number of units per week:

PSR group in the office number of units per week:

PSR group in the community number of units per week:

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

Service code: Number of units: per week

If the requested services are part of Permanent Supportive Housing (PSH): please ensure that the Louisiana Department of Health (LDH) notified AmeriHealth Caritas Louisiana BHUM directly to request an authorization for CPST-PSR with the PSH modifier.

For all initial requests, please indicate below:

1. **Treatment plan:** please clearly indicate the service (e.g., CPST or PSR) and what interventions (e.g., anger management, social skills, etc.) will be provided under each service requested. Please specify, for each intervention, the duration and frequency of delivery per week (e.g., 30-minute sessions, twice per week) and the number of weeks needed to complete one cycle of intervention (e.g, social skill training lasts 12 weeks, relaxation training, and practice sessions last eight weeks, etc.).

Problem/goal	**Mental health rehabilitation service**	**Type of intervention**	**Duration** (minutes) **and frequency** (sessions per week)	**Length of intervention** (weeks needed to complete one cycle)	**Who will provide the intervention?**

1a. If you are requesting to provide both CPST and PSR, please explain the need for both services and how the services will differ in content:

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

2. The member is unable to be managed at a less intensive level of care safely within the last week. ☐ Yes ☐ No

3. Is the member currently in short-term respite or any other mental health/substance use disorder service(s)?

☐ Yes ☐ No If yes, explain:

4. The member has displayed any of the following within the last week:

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

5. Have the behaviors been persistent for at least six months? ☐ Yes ☐ No

6. Are the behaviors expected to continue longer than one year without treatment? ☐ Yes ☐ No

7. The member has had unsuccessful treatment history (lack of improvement) in any of the following within the last month (check all that apply):

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

8. The member's support system is any of the following within the last month (check all that apply):

- ☐ Abusive
- ☐ Intentionally sabotages treatments
- ☐ Involved in treatment and treatment planning
- ☐ Unable to ensure safety
- ☐ Unable to manage the intensity of the member's symptoms without a structured program
- ☐ High risk environment (please specify what makes it high risk):

9. The member's living environment (please check one):

- ☐ Member is living in a safe environment
- ☐ Member is emancipated from family and lacks independent living skills
- ☐ Member has demonstrated intolerance for family environment or adult authority and needs out of home placement (child/adolescent)

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

- ☐ Activities of daily living (ADLs)
- ☐ Community living
- ☐ Social relationships
- ☐ Family relationships
- ☐ School performance

For all continued stay requests, please indicate the below:

1. Within the last month the member has experienced and/or displayed the following (check all that apply):

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

2. The member is receiving the following services:

Treatment plan: please clearly indicate the service (e.g., CPST or PSR) and what interventions (e.g., anger management, social skills, etc.) will be provided under each service requested. Please specify, for each intervention, the duration and frequency of delivery per week (e.g., 30-minute sessions, twice per week) and the number of weeks needed to complete one cycle of intervention (e.g, social skill training lasts 12 weeks, relaxation training and practice sessions lasts eight weeks, etc.).

Problem/goal	**Mental health rehabilitation service**	**Type of intervention**	**Duration** (minutes) **and frequency** (sessions per week)	**Length of intervention** (weeks needed to complete one cycle)	**Who will provide the intervention?**

2a. If you are requesting to provide both CPST and PSR please explain the need for both services and how the services will differ in content:
2b. Provide reasons why clinic-based services are not an option for this member at this time:
3. Additional clinical information to support the medical necessity of the requested services: