Behavioral Health Services

Provider Guide

AmeriHealth Caritas®
District of Columbia

www.amerihealthcaritasdc.com

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How to contact the Behavioral Health Services team

Utilization Management phone: **1-877-464-2911**

Utilization Management fax: **1-855-410-6638**

Utilization Management Outpatient secure email: **IntegratedBHUMOPT@amerihealthcaritas.com**

Behavioral Health Network Management (contracting, credentialing, etc.): **1-866-506-6590**

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District of Columbia

Behavioral Health Services which require prior authorization

Prior authorization is required for IOP, PHP, SUD withdrawal management and residential services. PRTF, MH IP.

Procedure	Prior authorization required	Covered benefit for Medicaid		Comments
Intensive Outpatient Program (IOP	Yes	Yes		Prior authorization is required for all units.
Substance Use Disorders Residential Treatment services (RTF per diem, excludes room and board)	Yes	Yes		Prior authorization is required through MCO that does not exceed up to 15 days per calendar month. DBH must approve admission through designated assessment and referral site. We fund the first 15 – 30 days and then Comagine will handle the authorizations for ongoing service days until discharge
Psychiatric Rehabilitation Treatment Facility (PRTF)	Yes	Yes		For enrollees under age 22, only per RFP (C.8.2.13.15). Prior authorization is required for all units. DMH must approve admission. We fund the first 30 – 60 days and then the enrollee is disenrolled to FFS (we cover the first 30 consecutive days and then until the first of the next month).
Mental Health Inpatient (MH IP)	Yes	Yes		Prior authorization is required for all units. Precertifications are available 24/7.
Withdrawal Management Services	Yes	Yes		Prior authorization is required for all Units. Precertifications are available 24/7.
Mental Health Partial Hospitalization Program (MH PHP)	Yes	Yes		Prior authorization is required for all units.

How do I request an authorization for one of these services?

IOP: The Clinical Fax Form **is** required for all IOP and day treatment.

MH IP, PHP, Withdrawal Management and Residential SUD services can be requested via the Clinical Fax Form **or** by calling 1-202-408-4823 or 1-800-408-7510 from 8:00 a.m. – 5:30 p.m., Monday – Friday, to complete the precertification telephonically.

Behavioral Health Clinical Fax Form

Below are steps on how to complete the behavioral health clinical fax form:

1. Complete date and date of admission or service start.
2. Indicate:
    a. The type of review.
    b. The type of admission.
    c. The admission status.
3. Provider information: complete all fields.
4. Enrollee information: complete all fields.
5. Medications: complete all fields.
6. Complete (free form) presenting problems: be as specific as possible and include all clinical documentation available.
7. Is the enrollee attending groups? Yes, No, or NA.
8. Treatment history and current treatment participation: Be as specific as possible and include all clinical documentation available.
9. Substance abuse issues: be as specific as possible and include all clinical documentation available.
10. Discharge planning: be as specific as possible and include all clinical documentation available.

PRTF authorizations:

1. Provider submits a Psychiatric residential treatment facility (PRTF) referral by:
    a. Completing the PRTF form.
    b. Submitting all necessary supporting clinical documentation (see the PRTF Referral Form).
    c. Faxing these materials to 1-855-410-6638.
2. Behavioral health (BH) Utilization Management (UM) gathers all necessary clinical documentation, including the referral and assessments, etc.
3. A BH UM psychiatrist determines if medical necessity (per InterQual) is met for the request.
4. BH UM schedules a meeting with the BH UM psychiatrist, BH UM clinical care managers, providers of the enrollee (if applicable or necessary), probation officers (if applicable) and Department of Behavioral Health (DBH) Dr. Onyemenem and Dr. Raczynski.
    a. The meeting is to make a medical-necessity determination in conjunction with DBH.

5. If the decision is that Medical Necessity Criteria (MNC) are met for the service, BH UM notifies the provider and the referral source of the authorization.
6. Authorizations are valid for 60 days. If the enrollee has not been admitted to the PRTF, a BH UM staff member follows the case until the enrollee is admitted or 60 days have passed (whichever occurs first).
    a. ***If 60 days pass without an admission, a new referral and medical necessity decision are required.***
7. Once the enrollee is admitted, the BH UM staff ensures the authorization dates are accurate for the provider.
8. The enrollee will be dis-enrolled following 30 – 60 days after the admission, per policy. At that time, DBH or fee for service will begin providing coverage for the enrollee while he or she is in the PRTF.
9. Once the enrollee is discharged from the PRTF, AmeriHealth Caritas District of Columbia (DC) will return to

    providing the enrollee's coverage.

What will my authorization look like?
Your authorization will be returned to you via phone or fax, depending on the service.

Service	Notification type
Intensive outpatient program (IOP) or intensive day treatment (IDT)	Fax
Psychiatric residential treatment facility (PRTF)	Phone
Mental health inpatient (MH IP)	Phone
Mental health partial hospitalization program (MH PHP)	Phone
Withdrawal Management and SUD Residential Treatment Services	Phone

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Behavioral Health Fax Form

Today's date: **Start date of admission or service:**

Type of review	Type of admission		Admission status	Estimated length of stay
□ Precertification □ Continued stay □ Discharge	□ Intensive outpatient □ Mental health inpatient □ Partial hospitalization/day treatment	□ Substance use □ Detox □ Rehab	□ Voluntary commitment □ Involuntary commitment	_____ (days/units) **Readmission within 30 days?** □ Yes □ No

Enrollee information	
Enrollee name (last, first, middle initial):	
Eligibility ID number:	Date of birth:
Enrollee address:	
Emergency contact (other than primary caregiver):	Phone:
Legal guardian or parent:	Phone:

Provider information	
Facility or provider name:	NPI number or tax ID:
Attending M.D.:	Provider ID:
Facility or provider address:	
Utilization Management review contact:	Phone:
DSM-5 diagnoses (include mental health, substance use, and medical):	

Medications

Medication name	Dosage	Frequency	Date of last change	Type of change
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
				□ Increase □ Decrease □ D/C □ New
Additional information:				

Presenting problem or current clinical update (Include suicidal ideation, homicidal ideation, psychosis, mood/affect, sleep, appetite, withdrawal symptoms, chronic substance use.)

Eligibility ID number: _____

Treatment history and current treatment participation
Previous mental health or substance use inpatient, rehab, or detox:
Outpatient treatment history:
Is the enrollee attending therapy and groups? □ Yes □ No If yes, please specify:
Explain clinical treatment plan:
Family involvement and/or support system:

Substance use: □ Yes □ No
If yes, mental health services only, please explain how substance use is being treated:
If yes, please complete below for current American Society of Addiction Medicine (ASAM) dimensions and/or submit with documentation for substance use, intensive outpatient, partial hospitalization/day treatment, substance use detox, and substance use rehab.

Dimension rating	Current ASAM dimensions are required (0–4)			
Dimension 1: Acute intoxication and/or withdrawal potential Ranking:	Substances used (pattern, route, last used):	Tox screen completed? □ Yes □ No If yes, results:	History of withdrawal symptoms:	Current withdrawal symptoms:
Dimension 2: Biomedical conditions and complications Ranking:	Vital signs:	Is enrollee under doctor care? □ Yes □ No Current medical conditions:	History of seizures? □ Yes □ No	
Dimension 3: Emotional, behavioral, or cognitive conditions and complications Ranking:	Mental health diagnosis:	Cognitive limits? □ Yes □ No	Psych medications and dosages:	Current risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):
Dimension 4: Readiness to change Ranking:	Awareness/commitment to change:	Internal or external motivation:	Stage of change, if known:	Legal problems/ probation officer:
Dimension 5: Relapse, continued use or continued problem potential Ranking:	Relapse prevention skills:	Current assessed relapse risk level: □ High □ Moderate □ Low	Longest period of sobriety:	
Dimension 6: Recovery/livin g environment Ranking:	Living situations:	Sober support system:	Attendance at support group:	Issues that impede recovery:

Discharge planning	
Discharge planner name:	Discharge planner phone:
Residence address upon discharge:	
Treatment setting upon discharge:	Treatment provider upon discharge:
Has a post-discharge seven-day follow-up appointment been scheduled? □ Yes □ No	
If no, please explain:	
If yes, give treatment provider name and date and time of scheduled follow-up:	

When form is complete, please fax to **1-855-410-6638**.

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Behavioral Health Discharge Note

Behavioral health inpatient

Date:

Please fax to 1-855-410-6638 24 hours before discharge.

Contact information		
Enrollee name:	Enrollee ID number:	Enrollee date of birth:
Enrollee address:		Enrollee phone number:
Name of facility:		Facility NPI number:

Date of admit:	Discharged to (home, foster care, shelter, etc.):
Date of discharge:	Discharge address:
Discharge phone number:	If a minor or dependent adult, name and contact information of parent or guardian:

ICD-10 discharge diagnoses (psychiatric, substance use, and medical)	
Was this discharge against medical advice (AMA)?	□ Yes □ No
Was discharge information sent to the primary care provider and psychiatrist?	□ Yes □ No
Was the discharge plan discussed with the enrollee?	□ Yes □ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to the parent or guardian? (This is also applicable for adults who have legal guardians.)	□ Yes □ No

Were any of the following included in the discharge plan? (Complete all that apply.)	
Referral to patient discharge coordination team? Comments:	□ Yes □ No □ Refused

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Referral to SUD residential treatment provider? Comments:	□ Yes □ No □ Refused

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

Were any of the following included in the discharge plan? (Complete all that apply.)	
Department of Behavioral Health? Comments:	□ Yes □ No □ Refused
Other (mental health therapy, medical management, Alcoholics Anonymous, Narcotics Anonymous)? Provider name: Address: Phone number:	□ Yes □ No □ Refused

Collaboration of needs (Please indicate if collaboration is needed with any of the below, including contact name and phone number.) Check all that apply.

	Yes	No	Contact information
Child or adult protective agency			
Jail, prison, or court system			
Juvenile justice			
Nursing or nursing home facility			
Residential program			

School system			
Other			

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

Discharge medications (Include all medications, including medical. Please provide dose, frequency, and condition for which each medication is prescribed.)	
Are these medications on the formulary?	□ Yes □ No
Do these medications require precertification?	□ Yes □ No
Has precertification been received, if needed?	□ Yes □ No

Risk assessment (If no risk assessment was performed, please explain.)
Was the enrollee stable at discharge (no risk for suicide, homicide, or psychosis)?

Aftercare appointment 1 (must be within seven days)	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Is aftercare appointment scheduled within seven calendar days? If no aftercare appointment is scheduled within seven calendar days, please explain why:	□ Yes □ No

Aftercare appointment 2	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Comments:	

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

Are any other providers involved in the aftercare plan? (If yes, please list below with contact information.)
Form submitted by:
Phone number of person submitting form:
Date form submitted:

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

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Substance Use Discharge Note

Date:

Please fax to 1-855-410-6638 24 hours before discharge.

Contact information		
Enrollee name:	Enrollee ID number:	Enrollee date of birth:
Enrollee address:		Enrollee phone number:
Name of facility:		Facility NPI number:

Date of admit:	Discharged to (home, foster care, shelter, etc.):
Date of discharge:	Discharge address:
Discharge phone number:	If a minor or dependent adult, name and contact information of parent or guardian:

ICD-10 discharge diagnoses (psychiatric, substance use, and medical)	
Was this discharge against medical advice (AMA)?	□ Yes □ No
Was discharge information sent to the primary care provider and psychiatrist?	□ Yes □ No
Was the discharge plan discussed with the enrollee?	□ Yes □ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to the parent or guardian? (This is also applicable for adults who have legal guardians.)	□ Yes □ No

Discharge medications (Include all medications, including medical. Please provide dose, frequency, and condition for which each medication is prescribed.)	
Are these medications on the formulary?	□ Yes □ No
Do these medications require precertification?	□ Yes □ No

Has Medication-Assisted Treatment been prescribed for the enrollee?	□ Yes □ No

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

Risk assessment (If no risk assessment was performed, please explain.)

Was the enrollee stable at discharge (no risk for suicide, homicide, or psychosis)?

Follow-up and/or transition to lower level of care

Please contact the Addiction Prevention and Recovery Administration (APRA) at **202-698-6080** for transitions to lower levels of substance use care, except intensive outpatient services, which must be authorized through the AmeriHealth Caritas District of Columbia Behavioral Health Utilization Management department at **1-877-464-2911**.

Was enrollee transitioned to lower level of care?

If yes, please provide specifics below, such as level of care, expected start date, and expected duration of treatment.

If no, please explain:

Are any other providers involved in follow-up care? (Please list below with contact information.)

Form submitted by:
Phone number of person submitting form:
Date form submitted:

Provider/facility notice:
Please remember to obtain any necessary patient authorization for the disclosure of treatment-related information and other protected health information to AmeriHealth Caritas District of Columbia.

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Psychiatric Residential Treatment Facility Referral

Psychiatric residential treatment facility (PRTF) referral information	
Date of referral:	
Referral contact:	Referring facility or agency:
Phone number:	Fax number:

PRTF referrals made

Has the enrollee been accepted at a PRTF? □ Yes □ No

If yes, please list actual facilities in the table below. If no, please list the facilities that the referring agency has identified for possible placement.

PRTF name	Accepted	Not Accepted	Awaiting decision	Is the facility recognized as a PRTF by DC Medicaid? (Y/N)

Date of admission or potential admission to PRTF: _____

Demographic information		
Child's name:		□ Male □ Female
Date of birth:	Age:	Ethnicity:
Current placement:		Admission date:
Social Security number:	Primary language:	Medicaid ID number:
Address:		
City:	State:	ZIP code:
Home phone number:		

Emergency contact (other than primary caregiver):_____Phone:_____

Guardian 1	Guardian 2
Name:	Name:
Relationship to child:	Relationship to child:
Ethnicity:	Ethnicity:
Languages:	Languages:
Address:	Address:
Home phone:	Home phone:
Work phone:	Work phone:

Legal guardian (if other than listed above):		
Relationship to child:	Home phone:	Work phone:

Child and Family Services Agency (CFSA) involvement (if any)	
CFSA supervisor:	Phone:
CFSA program supervisor:	Phone:
CFSA social worker or area office:	Phone:

Reason for and level of CFSA involvement:

Client CFSA status:					
□ Order of Temporary Custody	□ Committed	□ Voluntary	□ Family with service needs	□ Investigation	□ Protective

Juvenile court involvement (if any)	
Probation officer:	Phone:

Arrest history:

Criminal charge	When	Where	Disposition

Current family situation

Living situation (include the names and ages of other people in the household and their relationships to the enrollee):

Family history, family psychiatric and substance use history, domestic violence history, and current family stressors that may be affecting enrollee:

Family's role in treatment:

Family's strengths:

Child's strengths:

Religious and/or cultural background:

Restrictions or special needs based on religious and/or cultural background or physical needs (if any):

Secondary insurance information (if any)	
Name of secondary insurance carrier:	
Insurance number:	Plan or code number:
Subscriber:	Date of birth:
Subscriber's employer:	
Relationship to insured:	
Insurance verified: □ Yes □ No	

Psychiatric clinical information

What is the main clinical need or focal problem that leads you to request admission to a PRTF?

What are the contributing factors to the main clinical need or focal problem? Please consider factors from multiple life domains, including the individual, family, peer, school, and community:

What are the goals for the PRTF stay and the recommended interventions corresponding to the contributing factors stated above?

Current diagnosis	

Current psychiatric medications and dosages				
Name of drug	Dose	Schedule	Prescribing M.D.	Target symptoms or behaviors

Past psychiatric medication trials				
Name of drug	Dose	Schedule	Prescribing M.D.	Target symptoms or behaviors

Were any medications discontinued due to adverse reactions? If so, which?

Has the child experienced any of the following? (Please check one response for each.)

Symptom, behavior, or diagnosis	Current	Past	Unknown	N/A
Aggressive behavior				
Anxiety or panic attacks				
Attention-deficit/hyperactivity disorder				
Depression				
Disordered eating patterns or concerns				
Dissociative features				
Fire setting				
Hallucinations — auditory				
Hallucinations — visual				
History of cruelty to animals				
Homicidal threats				
Impulsive behavior				
Juvenile court involvement				
Oppositional behavior				
Running away				
Self-injurious behavior				
Sexualized behavior				
School problems				
Sleep problems				
Suicidal ideation				
Suicide attempts				

History of trauma or abuse: □ Yes □ No □ Unknown

If yes, please explain when and by whom and if enrollee has received any treatment to address:

Medical information	
Primary care provider:	Phone:

Allergies:

Check all that apply:

□ Birth complications □ Head trauma □ Gastrointestinal disease □ Diabetes □ HIV/AIDS

□ Asthma □ Cardiac problems □ Thyroid disease □ Seizures

Medical issues (including significant medical history, hospitalizations, and surgeries)

Recent testing	Date	Any abnormalities? (Y/N)	Comment
Electrocardiogram			
Electroencephalogram			
Computed tomography scan			
Magnetic resonance imaging			

Identify any potential risk factors that may interact with medications:

Current medical medications:

Name of drug	Dose	Schedule	Prescribing M.D.	Target symptoms or behaviors

Any medical conditions that might impact use of restraint:

Educational information	
Child's current grade level:	
Current school or town:	
Special education classification? □ Yes □ No	
IQ testing date:	IQ scores:
Current individualized education plan (IEP) date:	

Academic, behavioral, and social functioning in school (note any suspensions):

Treatment history and plan		
Has child ever received any of the following services?	**Y/N/U**	**Location**
Psychiatric hospitalization		
Substance use treatment		
Combined behavioral intervention		
Multisystemic therapy		
Outpatient treatment		
Partial hospitalization		
Residential treatment		
Psych-sexual evaluation		
Psychological testing		
Neuropsychological testing		
Other:		
Other:		
Other:		
Other:		
Other:		

What is the long-term disposition plan for this child?

□ Reunification with the following person: _

□ Therapeutic foster care

□ Residential treatment

□ Group home

What is the child's vision for the long-term disposition plan?

□ Home □ Therapeutic foster care □ Residential treatment □ Group home

Current service providers				
Contact name	Agency	Phone	Service provided	Dates of participation

Does the child require a single room? If yes, state reason:

Previous experience with roommates:

Criteria section

Expectation for treatment (check one):

- □ Treatment expected to improve symptoms behaviors
- □ Treatment expected to maintain symptoms or or behaviors without further deterioration

Over the last week, has the child or adolescent exhibited any of the following behaviors? (Check all that apply.)

- □ Fire setting
- □ Self-mutilation
- □ Running away for more than 24 hours
- □ Daredevil or impulsive behavior
- □ Sexually inappropriate, aggressive, or abusive behavior
- □ Angry outbursts or unmanageable aggression
- □ Positive, unmanageable psychotic symptoms
- □ Increasing, unmanageable hypomanic symptoms
- □ Arrest or confirmed illegal activity
- □ Persistent violation of court orders

Have the child or adolescent's behaviors been present at least six months? □ Yes □ No

Are the child or adolescent's behaviors expected to persist longer than one year without treatment?
□ Yes □ No

Has child or adolescent had any of the following unsuccessful treatments within the past year? (Check all that apply.)

- □ Treatment foster care
- □ Treatment in a residential treatment center or therapeutic group home
- □ At least three psychiatric inpatient admissions
- □ At least three psychiatric partial hospital admissions
- □ At least four psychiatric admissions to inpatient, partial hospital, or intensive outpatient, in any combination

Are the child or adolescent's behaviors unmanageable safely in a lesser level of care? □ Yes □ No

Is the child or adolescent's support system (check any of the following):

- □ Unavailable
- □ Unable to ensure safety
- □ A high-risk environment
- □ Abusive
- □ Intentionally sabotaging treatment
- □ Unable to manage intensity of symptoms

Does the child or adolescent have any of the following functioning problems? (Check all that apply.)

- □ Inability or unwillingness to follow instructions activities or negotiate needs
- □ Inability or unwillingness to perform of daily living
- □ Social withdrawal
- □ Loss of behavioral control for more than 48 hours, with no improvement expected within two weeks

Signature and title of referring person:_____

Date: _____

Supporting documentation required with packet:

- Court order for placement (if applicable)
- Most recent psychiatric evaluation recommending PRTF placement
- Most recent clinical update, including diagnosis and medications
- Most recent IEP
- Clinical justification: If the enrollee has not had extensive outpatient services, please provide clinical justification for placing the enrollee in a PRTF instead of starting more intensive outpatient services

Please note: Facilities may require additional documentation or information prior to decision.

5400ACDC-1522-31

Psychological and Neuropsychological Testing

AmeriHealth Caritas District of Columbia (DC) requires **prior** authorization for all psychological testing and neuropsychological testing.

What you need before requesting psychological or neuropsychological testing:

- A completed assessment on the enrollee that clearly documents the need for psychological or neuropsychological testing, including the questions to be answered and how the testing will impact the enrollee's treatment plan.

What you need to submit for a request to provide psychological or neuropsychological testing:

- A completed assessment on the enrollee.
- The completed Psychological or Neuropsychological Testing Request Form.

The Psychological and Neuropsychological Outpatient Treatment Request Form How to complete:

1. Enrollee information: complete all fields.

2. Provider information: complete all fields.

3. Referral reason or question: the reason the testing is being requested. What is the reason for the testing?

4. Double check that the testing being requested is not for the following:
    a. Educational and vocational purposes.
    b. Legal purposes.
    c. Experimental purposes or purposes that have no documented validity (i.e., no evidence-based outcomes).
    d. Time requested to administer the testing exceeds established time parameters.
    e. Routine entrance into a treatment program.

5. Note if this testing is required for educational purposes, behavioral health purposes or both.

6. State how the anticipated results of the testing will affect the patient's treatment plan.

7. DSM V Diagnosis: complete all fields.

8. List current medications with names, strengths and directions.

9. Check all current symptoms prompting the request for testing.

10. Was a Behavioral Health Evaluation completed? If so, give specifics. Attach results for more clarity and support of the request.

11. History: complete all fields.

12. Note if previous psychological or neuropsychological testing was conducted.

13. Complete the below box for services requested. As an example only:

Start date MM/DD/YY	Stop date MM/DD/YY	CPT code	Modifiers	Units requested
07/31/14	08/31/14	96101	TM	6

14. List the tests planned and the time you will spend administering each test.

Example:

Test	Reason for use	Educational (Yes or no)	Number of units requested for test	Number of units approved for test
WAIS-IV	Full IQ scale	No	4 hours	4 hours
MMPI-2	Personality inventory	No	4 hours	4 hours

15. Indicate total number of units or hours requested.

16. Provider signature.

What happens after you submit the request for testing?

If all required information is received:

- AmeriHealth Caritas DC processes the request.
  - All psychological and neuropsychological testing requests are sent to a licensed psychologist for review of medical necessity.
  - The psychological advisor makes the determination based on medical necessity for approval of the requested testing, the number of hours authorized and the types of test that are medically necessary to administer.
  - AmeriHealth Caritas DC then notifies you of the psychological advisor's medical necessity decision.

Problems and troubleshooting

1. **My request for authorization was pended, what happens now?**
    - **a.** AmeriHealth Caritas DC will send it back to you requesting the information we need and a date the clinical information is due.
        - i. The sooner the clinical documentation is submitted, the sooner an authorization can be processed.
    - **b.** The request will remain pending the authorization until the information is received.
    - **c.** AmeriHealth Caritas DC will pend the authorization request for at least 45 days.
    - **d.** On the 45th day, the authorization request will be reviewed for a possible denial of service(s) if the clinical documentation has not been received.

2. **Possible reasons for pending:**
    - **a.** The identifying information on the enrollee does not match AmeriHealth Caritas DC records.
    - **b.** Information is missing.
    - **c.** The information is not legible.
    - **d.** The address or service site is not listed in the provider profile.
    - **e.** The individual is not an active enrollee or the enrollee's identity cannot be verified.
    - **f.** The identifying information on the enrollee does not match AmeriHealth Caritas DC records.
    - **g.** A treatment plan is required but was not sent with the request.

3. **My authorization dates do not match what I requested:**
    - **a.** Check to ensure you are not requesting backdating of services.
    - **b.** Contact the BH UM department for further clarification.
    - **c.** Resubmit the request with proof of prior submission for backdating of services.

4. **I received an administrative denial notification that the enrollee is no longer eligible for AmeriHealth Caritas DC coverage. What should I do now?**
    - **a.** Check with DC Medicaid for guidance on the enrollee's current eligibility.

5. **I received notification that AmeriHealth Caritas DC Behavioral Health Utilization Management department could not verify the enrollee's identity. What do I do now?**
    - **a.** Resubmit **all** documentation initially submitted.
    - **b.** Be sure to include two of the following:
        - i. Enrollee name and AmeriHealth Caritas Date of birth
        - ii. Medicaid ID number
        - iii. DC ID
        - iv. Social security number

Important things to remember when requesting a behavioral health outpatient authorization:

1. Outpatient Therapy sessions do not require a prior authorization for participating providers. Non- participating providers will need to submit a Behavioral Health Outpatient Treatment Request (OTR) form.

2. Non-Participating Providers: The Behavioral Health Outpatient Treatment Request OTR requires a treatment plan. (The treatment plan should document the enrollee's measureable treatment goals with clearly defined time frames of treatment, progresses made, barriers, and future plans and interventions). **This is required to determine medical necessity for services.**

3. All written treatment requests received are date-stamped with the date received. The fax cutoff deadline is 5:30 p.m. EST daily. Requests received after 5:30 p.m. EST or on non-work days will be marked as being received on the date of the next business day.

4. Authorizations will not be backdated prior to the date the request, with all required information, was received by the BH UM department. Providers can file a dispute once a claim has been denied for services rendered that were not authorized due to provider failure to request authorization and/or provide sufficient clinical information to enable a medical necessity review.

If you believe you submitted a complete request before the date services were authorized to begin, please submit documentation of the prior submission and we will backdate the authorization with proof of submission (i.e., the date or time stamp from fax and/or electronic submission).

5. Complete treatment requests will be reviewed for medical necessity and duplication of services. If there is a duplication of services, the request will be returned to the provider requesting a rationale for the duplication.

6. AmeriHealth Caritas DC has no longer than 14 calendar days to process the request and notify the provider of the authorization outcome. If the 14-calendar-day deadline is missed, the request will be approved exactly as requested.

What will my authorization look like?

All authorizations are faxed to the provider at the given fax number. Below is an example of an authorization fax. Please remember to read **all** of the information on the fax cover sheet.

RightFax 7/28/2014 2:34:52 PM PAGE 1/001 Fax Server

AmeriHealth Caritas
District of Columbia

Facsimile Transmittal

To: Provider's Name

Company:

Fax: **18554106638**

Phone:

From:
Phone:

NOTES: Enrollee Name: Jane Doe
Authorization #: 123456789

Encounters: 96101
3 hours
Dates: 7/17/14-12117/14

Authorization is based on medical necessity or plan guidelines and not available benefits.

Confidentiality Statement: The documents accompanying this transmission contain confidential health information that is legally protected. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disdosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Date and time of transmission: 7/28/2014 2:34:12 **PM**

Number of pages including this cover sheet: 1

PAGE 111 • RCVDAT 712812014 2:34:52 PM (Eastern Day1Ight Tim e] " SVR:KMHPRFAXPA2217 • DNIS:1047109" CSID:RIghtFax • DURATION (mm -ss):00-33

AmeriHealth Caritas
District of Columbia

Psychological and Neuropsychological Testing Request

Please print clearly — incomplete or illegible forms will delay processing.

Enrollee information	Provider information	
Patient name: _____	(Please indicate by checking below whether requested services should be authorized to the provider or agency.)	
Health plan: _____	□ Provider	
Date of birth: _____	□ Group or agency	Name:
Social Security number: _____	Professional credential: □ M.D. □ Ph.D. □ Other:	
Patient ID number: _____	Physical address:	
Referral source: _____	Phone:	Fax:
	Medicaid/TPI/NPI number:	Tax ID number:

Referral reason or question:

Testing will not be authorized under any of the following conditions:

1. Testing is primarily for educational or vocational purposes
2. Testing is primarily for legal purposes
3. The tests requested are experimental or have no treatment program documented validity
4. The time requested to administer the testing exceeds established time parameters
5. Testing is routine for entrance into a

Is this testing required for educational purposes, behavioral health purposes, or both? Explain:

State how the anticipated results of the testing will affect the patient's treatment plan:

DSM V Diagnosis	What are the current symptoms prompting the request for testing?
Danger to self or others? □ Yes □ No If yes, please explain:	

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District of Columbia

Mental status exam (MSE) within normal limits? □ Yes □ No

If no, please explain:

□ Anxiety
□ Depression
□ Inattention
□ Confusion
□ Hypoactivity
□ Hyperactivity
□ Psychosis/ Hallucinations
□ Bizarre behavior
□ Unprovoked agitation or aggression
□ Self-injurious behavior
□ Eating disorder symptoms
□ Withdrawing or poor social interaction
□ Mood instability
□ Changes in memory capacity
□ Changes in cognitive capacity
□ Behavior problems affecting life functions (e.g., school, home)
□ Poor academic performance
□ Other:

List current medications:	
Name and strength	Directions

Comments

Was a behavioral health evaluation completed (e.g., 90801)?

□ Yes □ No Date: _____

Results:

_____

_____

Was previous psychological or neuropsychological testing conducted?

□ Yes □ No Date: _____

Basic focus and results:

History

When was the patient's last physical examination?

If attention-deficit/hyperactivity disorder (ADHD) is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available:

□ Positive □ Negative □ Inconclusive □ NA

Comments:

Start date requested MM/DD/YY	Stop date MM/DD/YY	CPT code	Modifiers	Units

Please list the tests planned to answer the clinical questions.

Test	Reason for use	Educational (yes or no)	Number of units requested for test	Number of units approved

for test				

Psychological and Neuropsychological Testing Request

Indicate the total number of units (hours) requested:
Provider signature:
Date:

☐ Submit to:
AmeriHealth Caritas DC Utilization Management Fax: **1-855-410-6638**
For assistance, please call **1-800-408-7510**.

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AmeriHealth Caritas
District of Columbia

Behavioral Health Outpatient Therapy

Behavioral health outpatient services

Please refer to your Current Procedural Terminology (CPT) Manual to obtain coding for outpatient behavioral health services. For fee information, you may visit the District of Columbia Department of Health Care Finance website at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleInquiry. Please contact your Provider Network Account Executive if you have any questions.

Enrollees may self-refer to behavioral health services.

Prior authorization is required only for all encounters/services provided by non-participating providers.

Behavioral Health Outpatient Treatment Request (OTR) Form

The behavioral health OTR is included with this guide (a blank copy and an example version). The document can also be found at http://www.amerihealthcaritasdc.com/provider/resources/forms.aspx.

Section Enrollee information: complete all fields.
Tip: The enrollee must have current and active coverage with AmeriHealth Caritas DC during the time of the requested services. AmeriHealth Caritas DC must verify the enrollee's identity and eligibility through two of the following from the enrollee:

1. Enrollee name.
2. Medicaid ID number.
3. Social Security number.
4. Date of birth.

If we are unable to verify enrollee's identity, we cannot document and/or save the request. If we are unable to verify the enrollee's identity, you will receive one of the below notifications via fax:

We are unable to process this request because we cannot confirm enrollee identity and eligibility. Please provide at least one enrollee identifying number, such as Medicaid ID number, AmeriHealth Caritas DC ID number, or Social Security number, so we may confirm enrollee identity and process this request.

Please note that to verify eligibility, we need to match our records with the request on at least two of the following:

1. *Enrollee name.*
2. *Medicaid ID number.*
3. *Social Security number.*
4. *Date of birth.*

We are unable to process this request because we cannot confirm enrollee identity and eligibility. The [Enrollee name, Medicaid ID number, Social Security number, Date of birth] provided does not match our records. Please confirm enrollee identity and eligibility with AmeriHealth Caritas DC Medicaid. If the enrollee is active with AmeriHealth Caritas DC, please resubmit with correct enrollee information. Please note that to verify eligibility, we need to match our records with the request on at least two of the following:

1. *Enrollee name.*
2. *Medicaid ID number.*
3. *Social Security number.*
4. *Date of birth.*

If the enrollee is no longer eligible for benefits with AmeriHealth Caritas DC during the time the services are requested, we will issue an administrative denial for the termination of benefits.

Section Treating provider information: complete all fields.
Tip: enter the fax number that the authorization should be faxed back to.

Section Reason for services: complete all fields.

Section DSM diagnosis and questions following: complete all fields including diagnosis.

Section Reason for authorization of out-of-network providers: complete all fields or check "Not applicable."

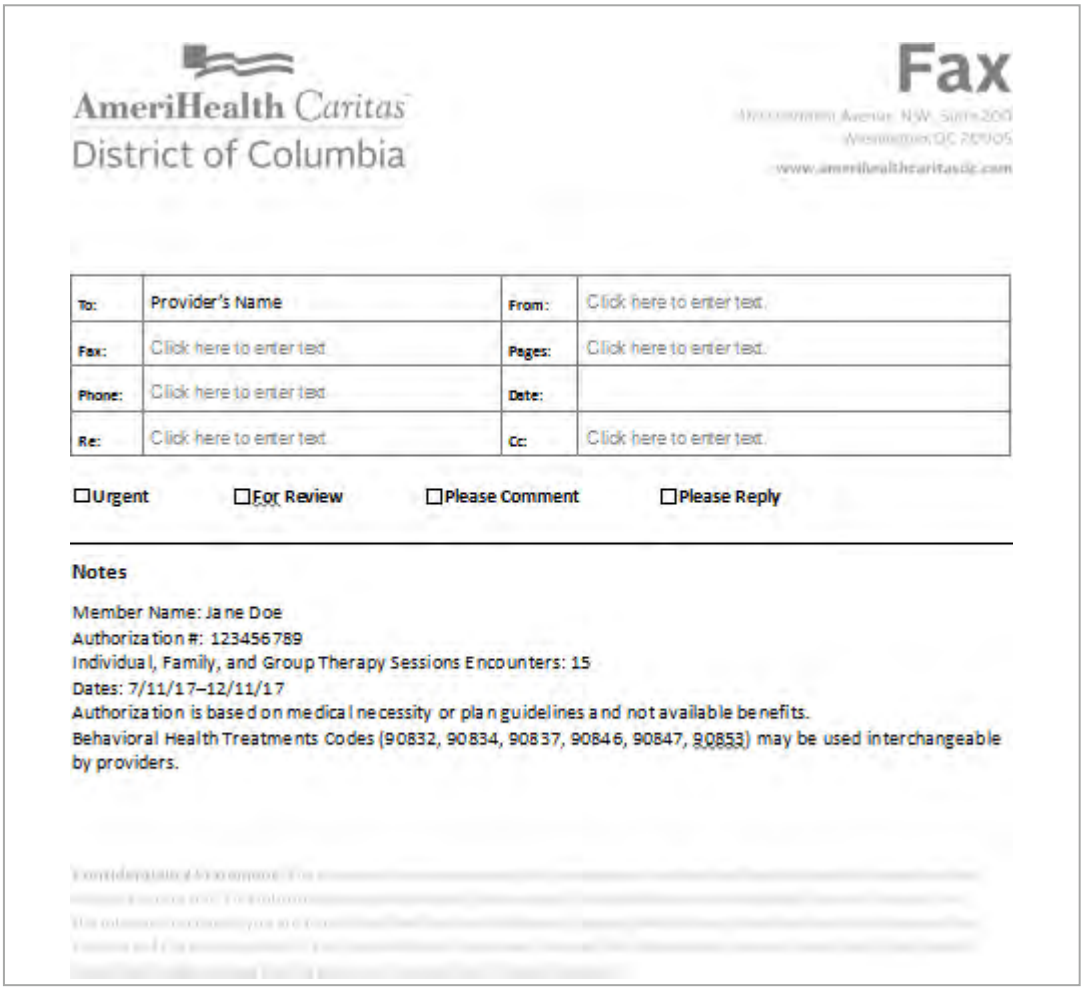
Section Medications: complete all fields.

Section Treatment plan: attach the current treatment plan.

Section Additional comments: enter any necessary information.

What will my authorization look like?

All authorizations are faxed to the provider at the given fax number. Below is an example of an authorization fax. Please remember to read all of the information on the fax cover sheet.



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District of Columbia

Fax

To:	Provider's Name	From:	Click here to enter text.
Fax:	Click here to enter text	Pages:	Click here to enter text.
Phone:	Click here to enter text	Date:	
Re:	Click here to enter text	Cc:	Click here to enter text.

☐Urgent ☐For Review ☐Please Comment ☐Please Reply

Notes

Member Name: Jane Doe
Authorization #: 123456789
Individual, Family, and Group Therapy Sessions Encounters: 15
Dates: 7/11/17–12/11/17
Authorization is based on medical necessity or plan guidelines and not available benefits.
Behavioral Health Treatments Codes (90832, 90834, 90837, 90846, 90847, 90853) may be used interchangeable by providers.

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District of Columbia

Outpatient Treatment Request (OTR)

Please print clearly — incomplete or illegible forms will delay processing. Please return to AmeriHealth Caritas District of Columbia (DC) via fax at **1-855-410-6638**. For assistance, please call **1-800-408-7510**.

Enrollee information

Enrollee name:_____ Medicaid number:_____ Social Security number: __

Date of birth:_____ Enrollee address: _____

City:_____ State:_____ ZIP:_____ Phone: _____

Who referred enrollee for treatment?

Self or guardian Primary care provider (PCP) School State agency:__

_____ Other:_____ Name of referring agent:__

_____ Phone: _____

Treating provider information

Name:_____

☐ M.D. ☐ Licensed ☐ Licensed clinician

National provider identifier (NPI) number:_____ ☐ In network ☐ Out of network ☐ In credentialing process

Address: _____

City:_____ State:_____ ZIP:_____ Phone:_____ Fax:_____

Group name or AmeriHealth Caritas DC ID number: _____

Contact name:_____
Treating provider signature: _____

Reason for services

Primary reason or complaint:_____

Start date requested: _____

Services requested:_____ Service codes:_____ Frequency:_____

DSM diagnosis	Please answer the following questions
List all DSM diagnoses (behavioral and medical):	a) Is the enrollee currently participating in any school services? Yes No b) Is the enrollee's family or supports involved in treatment? Yes No c) Has the enrollee been evaluated by a psychiatrist? Yes No d) Is the enrollee involved with juvenile justice or the Child and Family Services Agency (CFSA)? Yes No e) Is there coordination of care with other behavioral health providers? Yes No f) Is there coordination of care with medical providers? Yes No

Reason for authorization of out-of-network providers

(Utilization Management will contact provider directly before giving authorization.)

☐ Not applicable — provider is in network.

a) Specialty of provider to meet the needs of the enrollee:

b) Continuity of care concerns:

c) Accessibility and availability of provider:

d) Clinical rationale:

Medications

Is enrollee on prescribed medications? Yes No Prescribing physicians' names: _____

Is enrollee compliant with medications? Yes No Please list medications and dosages: _____

Treatment plan

Please attach the current treatment plan.
Please include documentation related to progress on goals and any changes made as a result.

Additional comments

Submit to:
AmeriHealth Caritas DC Utilization Management Fax: **1-855-410-6638**
For assistance, please call **1-800-408-7510.**

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