Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

MENTAL HEALTH SKILL-BUILDING (MHSS) H0046 INITIAL
Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian (if applicable):		Clinical Contact Name & Credentials*:	
Parent/Guardian (if applicable) Contact Information:		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

Request for Approval of Services: **Retro Review Request?** ☐ Yes ☐ No From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.	
Is this a new service for the member? ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)	
Primary ICD-10 Diagnosis	
Secondary Diagnosis	

SECTION I: MENTAL HEALTH SKILL-BUILDING ELIGIBILITY CRITERIA	
Individuals qualifying for Mental Health Skill Building Services (MHSS) must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized training to achieve or maintain stability and independence in the community. **Please describe member's current functional impairments:** **Please describe why MHSS services are required for member to achieve or maintain stability and independence in the community (Ex: recent increase in symptoms/decrease in functioning? Transitioning to an independent living setting? Current risk of homelessness or hospitalization?):**	☐ Yes ☐ No

Member's Full Name: Medicaid #:

The individual shall have one of the following as a primary diagnosis: **1. Schizophrenia or other psychotic disorder as set out in the DSM** **2. Major Depressive Disorder — Recurrent** **3. Bipolar I or Bipolar II** **4. Any other DSM mental health disorder that a physician has documented specific to the identified individual within the past year to include all the following:** **i. that is a serious mental illness;** **ii. that results in severe and recurrent disability;** **iii. that produces functional limitations in the individual's major life activities that are documented in the individual's medical record, and;** **iv. that the individual requires individualized training to achieve or maintain independent living in the community.**	☐ Yes ☐ No
The individual requires training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management. **Please describe member's current skill level and abilities - be specific to track progress or lack of progress: (Provide examples; Identify - frequency, severity, and duration of each behavior)**	☐ Yes ☐ No
Prior to starting MHSS services the individual has been determined to have a prior history of psychiatric hospitalization, residential crisis stabilization, ICT or Program of Assertive Community Treatment (PACT) services, placement in a psychiatric residential treatment facility, or Temporary Detention Order because of decompensation related to serious mental illness.	☐ Yes ☐ No
Prior to starting MHSS services the individual has a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within 12 months prior to the assessment date unless there is signed documentation from a physician or other licensed prescribing practitioner indicating that medications are contraindicated.	☐ Yes ☐ No
**** If under 21 years old — Member is in an independent living situation or actively transitioning into an independent living situation (not living with a parent or guardian or in a supervised setting and providing own financial support).**	☐ Yes ☐ No ☐ N/A

Name of Service	Date of Service	Reason for Admission

Name of Medication	Dosage	Frequency

☐ **No psychotropic medications prescribed, documentation of contraindication is attached**

SECTION II: CARE COORDINATION
Primary Care Physician:
Other medical/behavioral health concerns (including substance abuse issues, personality disorders, dementia, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)

Member's Full Name: Medicaid #:

Please indicate other medical/behavioral services and additional community supports/interventions received:		
Name of service/treatment	Provider/Contact Information	Frequency

Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:

Does the member currently have any services in place to assist with daily living skills, social skills, socialization, medication management, and money management? (Ex: Assisted living or group home staff, Psychosocial Rehabilitation, payee services, supportive friends or family). Please list any current services being provided to this member as described above:

If services are in place for this member, please clarify how additional Mental Health Skill-Building Services are necessary and will not duplicate the services member is currently receiving:

SECTION III: TRAUMA-INFORMED CARE

Trauma-Informed Care (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)

Is there evidence to suggest this member has experienced trauma? ☐ Yes ☐ No

What is your plan to assess/refer and address the current and potential effects of that trauma?

SECTION IV: INDIVIDUAL TREATMENT GOALS

Treatment Goals/Progress:

- Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions or referral in the treatment plan.
- Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential.
- Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress.
- Include any appointments and medications adherence issues and plans to address this, if applicable.

Member's Full Name: Medicaid #:

Resources and Strengths: Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.
Please describe any barriers to treatment:
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
Please describe where the member is now regarding this specific objective.
How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the training or interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
Please describe where the member is now regarding this specific objective.
How many days per week will be spent addressing this goal on average?

Member's Full Name: Medicaid #:

What specific training and interventions will be provided to address this goal?
How will you measure progress on the training or interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
Please describe where the member is now regarding this specific objective.
How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the training or interventions provided?

Member's Full Name: Medicaid #:

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

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

Signature (actual or electronic) of LMHP Type: _____

Printed name of LMHP Type: _____

Credentials: _____

Date: _____

Member's Full Name: Medicaid #:

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

Member's Full Name: Medicaid #:

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

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

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

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

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