PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MENTAL HEALTH INTENSIVE OUTPATIENT (MH-IOP: S9480) and
MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM (MH-PHP: H0035)

INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) is relevant and can be used for efficiency. There will also be sections in this form prompting creation of initial Individual Service Plan (ISP) goals, which providers must be complete prior to the start of services. Character limits have been established in most sections, please use the notes section to add additional information.

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:		Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name and Credentials*:	
		Phone #	
		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Type of Service Request Authorization

- ☐ Mental Health Intensive Outpatient {S9480}
- ☐ Mental Health Intensive Outpatient with Occupational Therapy {S9480, GO}. Please place evidence of the need for OT Services in the Notes Section of this form.
- ☐ Mental Health Partial Hospitalization Program {H0035}

Request for Approval of Services: **Retro Review Request?** ☐ Yes ☐ No

If the member is currently receiving MH-IOP/MH-PHP service, start date of service: _____

Proposed/Requested Service Information:

From_____(date), To_____(date), for a total of _____ units of service.

Plan to provide _____ hours of service per week.

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA & PRELIMINARY TREATMENT GOALS

Individuals must meet ALL of the criteria #1-8.

If individual is seeking admission to MH-PHP for Eating Disorder treatment, they must also meet criteria #9 and #10. Please develop 3 preliminary treatment goals based on the criteria cited below. A treatment goal section is provided below each criteria. Providers may decide with the individual which goals are most relevant at this time. The goal sections are marked with "Suggested and Optional" for this initial plan to provide general guidance on what goals are most informative for initial authorization decisions.

1. Specify the DSM diagnosis corresponding with the ICD-10 diagnosis(es) on the previous page. Describe the individual's current symptoms as well as their frequency, intensity and duration.
   The initial service and treatment plan proposed here should be reasonable to address these symptoms/diagnosis(es). Corresponding CNA Elements: 1, 12

Suggested Preliminary Treatment Goal #1: *Create a goal related to one or more of the symptoms noted above.*

2. To differentiate acuity of the individual's symptoms and appropriateness for these levels of care, please complete the following based on the level of care being requested for authorization:

   a. **FOR MH-PHP:** Describe symptoms specific to the last **14 days** and how their level of acuity has maintained or intensified for this individual. Describe any recent incidents that potentially triggered these symptoms. What has been the impact on their functioning at home, school, work or in their community? What negative consequences has this person experienced in their social relationships due to these issues? *Be specific about the frequency, intensity and duration of these symptoms over the last **14-day period** and connect these to the impact on functioning and relationships. The initial service and treatment plan proposed here should be reasonable to address these symptoms/diagnosis(es). Corresponding CNA Elements: 1, 6, 7, 13*

   b. **FOR MH-IOP:** Describe symptoms specific to the last **30 days** and how their level of acuity has maintained or intensified for this individual. What has been the impact on their functioning at home, school, work or in their community? What negative consequences has this person experienced in their social relationships due to these issues? *Be specific about the frequency, intensity and duration of these symptoms over the last **30-day period** and connect these to the impact on functioning and relationships. The initial service and treatment plan proposed here should be reasonable to address these symptoms/diagnosis(es). Corresponding CNA Elements: 1, 6, 7, 13*

Suggested Preliminary Treatment Goal #2: *Create a goal related to the individual's functioning and social relationships.*

3. Describe evidence that providers have attempted interventions at lower levels of care or in alternative, community-based rehabilitation services and the barriers to success in those efforts. What prevented these efforts in other services from working for this individual? *Explain why these efforts did not work for this person and what has happened to the person's symptoms and circumstances due to these challenges with other services. How will this service be a better fit for the individual's needs? Corresponding CNA Elements: 2, 3*

Identify in the table below any identified past and current service providers and the corresponding information:

Provider & Service	**Past or Current?**	**Start / End Dates of Service**	**Available Info on Outcomes/Current Progress**

4. The intention of MH-IOP and MH-PHP is to provide service options for both diversion and step-down from residential or inpatient hospitalization levels of care. *Corresponding CNA Element: 11*
   One of the following two criteria must be met:

   a. The individual is at risk for admission to inpatient hospitalization, residential treatment or residential crisis stabilization (or in the case of MH-IOP, risk of admission to MH-PHP) as evidenced by acute intensification of symptoms, but the individual has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision.

   OR

   b. The individual is stepping down from inpatient hospitalization, residential treatment or residential crisis stabilization (or in the case of MH-IOP admission, the individual is stepping down from MH-PHP) and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision.

   Describe the evidence, including symptoms/behaviors that demonstrate that either of these two scenarios are relevant for this individual. *Corresponding CNA Elements: 1, 11*

Suggested Preliminary Treatment Goal #3: *Create a goal related to the behaviors or symptoms that present the greatest risk in terms of safety/harm for the individual.*

5. To participate in these levels of care, an individual benefits from the involvement of natural supports, including caregivers or self-identified family/friends. Describe the community-based network of natural supports who are able to ensure the individual's safety outside the treatment program hours and the established safety plan. For youth, please specify which caregivers/family members will be actively involved in the treatment plan. *Corresponding CNA Elements: 7, 10*

Optional Preliminary Treatment Goal #4: *Create a goal related to supporting the maintenance or growth of natural supports for this individual in their path to recovery.*

6. Describe why an intensive, structured treatment program with an onsite multidisciplinary team, including psychiatric interventions for medication management is necessary to address and meet the individual's treatment needs. *Corresponding CNA Elements: 13, 14*

Identify all current/past medications, dosage and frequency:
Corresponding CNA Elements: 4

Name of Medication	Current / Past	Dosage	Frequency

Optional Preliminary Treatment Goal #5: *Create a goal related to treatment delivered by a multi-disciplinary team and/or medication management.*

7. Describe evidence that the individual is able to reliably attend, and actively participate in, all phases of the treatment program. *Corresponding CNA Element: 10*

List any potential barriers to engagement and participation as well as a list of potential solutions discussed with the individual for these treatment barriers. *Corresponding CNA Element: 13*

8. Describe evidence that the individual has demonstrated willingness to engage and recover in the structure of this type of treatment program. *Corresponding CNA Element: 10*

SECTION II: Mental Health-Partial Hospitalization Program <u>ONLY</u>
ADDITIONAL ADMISSION CRITERIA (for Eating Disorder treatment)
If an individual is being admitted to MH-PHP for treatment of an Eating Disorder, the individual must meet <u>two</u> sub-criteria within criteria #9 (9a, and/or 9b, and/or 9c) and criteria #10:

9. The individual exhibits symptoms consistent with an eating disorder diagnosis and requires at least **<u>two</u>** of the three following sub-criteria: *Corresponding CNA Element: 1*

9a. Weight stabilization above 80% IBW (or BMI 15-17) *If Yes, please describe current symptoms, behaviors and other pertinent information, which provides evidence that the individual needs this treatment intervention.*	☐ Yes ☐ No

9b. Daily, or near daily supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight management behavior (e.g. caloric restriction, intake refusal, vomiting/purging, excessive exercise, compulsive eating/binging). *If Yes, please describe current symptoms, behaviors and other pertinent information, which provides evidence that the individual needs this treatment intervention.*	☐ Yes ☐ No
9c. Individual has engaged in misuse of pharmaceuticals with an intent to control weight (e.g. laxatives, diuretics, stimulants) and cannot be treated at a lower level of care. *If Yes, please describe current symptoms, behaviors and other pertinent information, which provides evidence that the individual needs this treatment intervention.*	☐ Yes ☐ No
Suggested Preliminary Treatment Goal #6: *Create a goal related to weight stabilization and/or compensatory weight management behavior and/or misuse of pharmaceuticals.*	
10. Are there medical comorbidity or medical complications resulting from the eating disorder that require monitoring during PHP? *If yes, please identify plan to monitor and coordinate with medical provider and evidence that the individual does not require 24-hour medical monitoring in a hospital level of care. Corresponding CNA Element: 4*	☐ Yes ☐ No

Suggested Preliminary Treatment Goal #7: *Create a goal related to management of the medical co-morbidities or complications.*

Section V: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that sufficient progress has been achieved to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

What would progress/recovery look like for this individual?

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

What is the best estimate of the discharge date for this individual?

Member Full Name: Medicaid #:

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date(s): _____

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____

Date: _____

Notes Section