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) members. The process of coordinating member 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 members, 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 members, 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 members 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 upon request by calling CBH Provider Relations at (215) 413-7660 or by internet at http://www.dpw.state.pa.us/omap/rfp/lthchcrfplt/lthChBHAppdxT.asp. 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 expediant
- length of stays that are not medically warranted are prevented
- costs are controlled
Categories of Authorizations 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
- all Behavioral Health Rehabilitation Services (BHRS)
- all Family Based Services (FBS)
- all residential treatment services for children and adolescents
- all psychological testing
- all out-of-plan or out-of-area services
- community support services
- crisis residences (ICCMN, CMS)
- alcohol (ethanol) testing

- This clinical category includes initial and concurrent treatment episodes.

- Providers must follow the authorization process outlined under **Services That Cannot Begin Without Prior Authorization**.

- Community Support Services (TCM are authorized through DBH/IDS).

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

- adult partial hospitalization services
- all Intensive Outpatient Provider (IOP) services
- all emergency psychiatric evaluations

- This clinic 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.

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
- All initial and follow-up psychiatric consultations
- All Comprehensive Biopsychosocial Evaluations (CBEs) and Re-evaluations (CBRs)

This clinical category includes initial and concurrent treatment episodes.

Case Open Process

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

- Members who are newly enrolled in Medical Assistance. This includes members 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.

- Members who have never received inpatient or outpatient behavioral health services under CBH.

Providers should complete a CBH Case Open Request Form for members who meet the above criteria. The forms must be submitted on a weekly basis to the Operations Support Services 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 members are referred for treatment and the steps treatment providers must take to obtain authorization.

**DBH/CBH Referral and Authorization Process**

**Referrals come from**

- DBH/CBH Members and/or Family Members
- CBH Member Services Representative
- Social Service Organizations & Providers
  - Crisis Response Centers
  - Assessment Centers
  - Criminal Justice System
  - Treatment Providers
  - Phila. Dept. of Human Service (DHS)
  - School District of Phila.
  - Philadelphia Corporation for Aging
- CBH Care Manager

**Is prior authorization required?**

**YES**
- **LEVEL OF CARE IS IDENTIFIED**
  - Provider requests authorization from DBH/CBH Care Manager prior to treatment
  - If request meets medical necessity, DBH/CBH approves level of care. Authorization number issued at point of admission.

**INITIAL EPISODE OF TREATMENT and concurrent monitoring by DBH/CBH**
- If needed, provider requests authorization from DBH/CBH Care Manager for extended treatment.
- If request meets medical necessity, DBH/CBH authorizes extended treatment.

**CONTINUED TREATMENT**
- DBH/CBH coordinates discharge planning with provider and other components of DBH.

**NO**
- **TREATMENT IS INITIATED**
  - Provider requests authorization number, if required, after treatment begins and before billing CBH.

**CONTINUED TREATMENT**
- If clinically relevant, member continues treatment.
- Provider requests authorization prior to billing.
- DBH/CBH authorizes extended treatment.
CBH assists both members and providers as they proceed through the authorization process.

**For CBH Members Seeking Treatment**

**MEMBER SERVICES UNIT**

The CBH Member Services Unit is available for members or the parents/guardians of underage members 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 member to treatment services that may more closely meet the member’s needs.

**This unit is responsible for:**

- Confirming member's eligibility
- Collecting relevant demographic information about the member and reason for referral
- Scheduling appointments for assessments
- Determining special needs
- Making referrals to treatment providers
- Ensuring members have a choice of treatment program

Member Services Representatives will always attempt to conduct a three-way call with the member 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 member.

When members 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 and then notify the member 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 member.

This unit 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

Please refer to the UM guide for information regarding required documentation for authorization of levels of care that require prior authorization.

http://www.dbhids.org/assets/Forms--Documents/CBH/UMFULLrev0110.pdf

OBTAINING AUTHORIZATIONS FOR SERVICE

For Emergency Inpatient Mental Health and Drug & Alcohol Services call, Clinical Management 24 hours a day, 7 days a week at (215) 413-7171

For All Non-Emergent Services Requiring Prior Authorization, call Clinical Management Monday - Friday, 8:30am - 5:00 pm at (215) 413-3100

For All Non-Emergent Services Requiring an Authorization Number Complete an Outpatient Service Request Form and mail it to:

Operations Support Services
Community Behavioral Health
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 a payment for services rendered, providers must check the member’s eligibility. Providers can access 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

Initial Utilization Review

Utilization review documentation specific to levels of care are located in the Utilization Management Guide.

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
- all Behavioral Health Rehabilitation Services (BHRS), including School-based Behavioral Health Programs (SBBH)
- all Family Based Services (FBS)
- all residential treatment services for children and adolescents
- all residential treatment services for adults (RTFA, RINT)
- all psychological testing
- all out-of-network or out-of-area services
- community support services
- alcohol (ethanol) testing
Guideline 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**

- acute inpatient psychiatric hospitalization
- sub-acute inpatient psychiatric hospitalization
- 23-hour bed

**INPATIENT AND NON-HOSPITAL BASED DRUG AND ALCOHOL TREATMENT**

- hospital or non-hospital based detoxification
- hospital or non-hospital based residential rehabilitation
- half-way house

**Authorization Guidelines for Emergency Admissions**

The following are the authorization guidelines providers should follow when calling CBH on behalf of a member 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 that do not fall under emergent or urgent are considered routine.
EMERGENT AND URGENT AUTHORIZATION PROCEDURE:

In order to be precertified/preauthorized to an inpatient unit, a psychiatrist at a hospital emergency room, assessment center, or Crisis Response Center (CRC) must evaluate the member. This examination must include a Mental Status Evaluation (MSE). In order to be admitted to a medically managed or medically monitored detoxification, residential rehabilitation facility or half-way house, an adult or an adolescent according to the Adolescent ASAM should be assessed according to Pennsylvania Member 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 inpatient admission.

2. The Care Manager will request the member's MA number as well as Other Party Liability status, verify the member's eligibility for Medical Assistance, and request pertinent clinical information to support the mental health or drug and alcohol diagnosis, using the DSM-IV diagnostic criteria. Please refer to the Utilization Management Guide for assessment documentation required for providers should be prepared to discuss with a Care Manager when calling in for an Emergent or Urgent authorization.

3. If the DBH/CBH Care Manager agrees that the clinical information presented meets medical necessity, the Care Manager will authorize a specific level of care and length of time (i.e. number of days). DBH/CBH emphasizes member choice regarding placement. 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 provider will utilize the authorization report to verify the number.

To Call for Authorizations at Admission:
(215) 413-7171
Follow the prompts
Press "0" (zero) and "#" (number sign)

PLEASE NOTE

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

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 Department of Behavioral Health and Intellectual Disability Services (DBHIDS).

- The acute inpatient level of care will be determined in accordance with Medical Necessity Criteria outlined in Appendix T of HealthChoices.
- CBH will authorize placement and encourage treatment providers to enroll individuals in Medical Assistance, if they qualify, as soon as possible.
- Uninsured members in need of primary drug and alcohol treatment should be referred to the Behavioral Health Special Initiative (BHSI), 801 Market Street, Philadelphia, PA 19107, (215) 546-1200.
- 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 member through the use of the POSNET. 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 member through POSNET.
- 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 administrative 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 reviews with the treatment provider following the initial authorization period.
- Decisions to deny initial or concurrent stays will be reviewed through the physician review process.
- Once the approved criteria for County Funding have been met, complete the following guidelines:
  
  - Verify compliance to member liability determination standards for DBH programs. The provider hospital is responsible for conducting the assessment to determine the member's and/or their legal responsible relative's ability to cover the cost of care.
AUTHORIZATIONS

⇒ Verify that an MA application was made on behalf of the member upon hospital admission and that DPW rejected the member’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 member’s regarding DPW requirements.

⇒ If a member is determined to be financially liable, the hospital must make collection arrangements with the member. 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 Members With Medicare Fee-For-Service (FFS) as the Primary Carrier

When a CBH member 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, if managed medicare the provider must obtain pre-certification first.

⇒ Proceed with the pre-certification process if the member has no remaining covered days.

⇒ For further information regarding Third Party Liability billing, please refer to the Claims Section pgs 4.4-4.5. of this manual.

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 licensed psychiatrist prior to presenting the individual for admission must complete a psychiatric evaluation.

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 member’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 individual functioning. It’s 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.
- Member’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 member 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 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 member requires additional time in this level of care, a physician review will be completed to determine continued medical necessity. Authorizations will be granted according to the individual needs of the member and in conjunction with the physician review and recommendations for continued stay.
Notification regarding changes to the approval process for Acute Partial Hospitalization

Acute Partial Hospitalization Program Referrals:

Children and adolescents who are appropriate for the Acute Partial Hospitalization Program are those who:
- Are 5-18 yrs of age
- Are having severe behavioral problems in a school or other educational setting
- Have an extensive history of inability to function successfully in their current educational placement due to behavioral health challenges
- Have been unsuccessfully treated in lower levels of behavioral health treatment (such as, Outpatient, BHRS, School-Based Therapeutic Services)

Recommendations for children being referred to a Partial Hospitalization Hospital

Effective February 23, 2012 Community Behavioral Health (CBH) will require that all referrals for acute partial hospitalization (APHP) have a Mental Status Exam (MSE) completed by a psychiatrist or licensed psychologist within 24 hours prior to the request for this service. In addition, collateral information from the referral source (family, DHS, etc.) must be included in the completed evaluation. If the request is initiated by the school, supporting information (written or verbal) must be obtained. This information should include specific behaviors exhibited, onset of behaviors, duration and any interventions attempted to eliminate these behaviors prior to the request for APHP. Moreover, if a child or youth is authorized for services such as Behavioral Health Rehabilitation Services (BHRS), Family Based Services (FBS), Family Focused Behavioral Health (FFBH), or in Outpatient treatment, information from and collaboration with these service providers is required, from the point of admission into APHP, to inform treatment planning during APHP and as part of the discharge plan from APHP.

Although APHP is not an urgent level of care, the expectation is that children presenting for this service have had a recent episode of severe behavioral discord and are unable to be maintained in the community or school setting. The referral source should be the family, school, CRC or provider. Once contact is made to CBH and the requested information is obtained, a decision will be rendered regarding the approval or denial for the requested service. If APHP is not approved, the requesting facility can follow CBH protocol for exploration of alternative services.

Guidelines for Prior Authorization of BHRS, SBBH, FBS, and Residential Treatment Services

Community Residential Rehabilitation Host Homes (CRR-HH), Residential Treatment Facilities (RTFs), and Behavioral Health Rehabilitation Services (BHRS), School Therapeutic Services (STS), and Family Based Services (FBS) 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, STS, RTF, CRR-HH, and FBS 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**

<table>
<thead>
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<th>MA-97 OR MA-325</th>
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<tbody>
<tr>
<td>✷ Requests services accurately, including an appropriate start date.</td>
</tr>
<tr>
<td>✷ Signed by the youth, if the youth is age 14 or older, or parent/guardian, and prescriber. (Prescriber is the licensed psychologist or psychiatrist who completed the evaluation.)</td>
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<thead>
<tr>
<th>COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION (CBE)</th>
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<tr>
<td>✷ See UM Guide for CBE elements.</td>
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<tr>
<th>COMPREHENSIVE BIOPSYCHOSOCIAL RE-EVALUATION (CBR)</th>
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<td>✷ See UM Guide for CBR elements.</td>
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<tr>
<th>ADDENDUM TO COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION OR RE-EVALUATION (CBE OR CBR)</th>
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<tbody>
<tr>
<td>✷ Describes additional information since last evaluation.</td>
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<tr>
<td>✷ Contains 5-Axis, DSM-IV diagnoses.</td>
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<tr>
<td>✷ Recommends specific services.</td>
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PLAN OF CARE (ATTACHMENT 6 OR 7) - not required for submission, but must be kept on file at provider site in member’s record

✦ Lists all services including school, community resources, DHS, etc.

✦ Includes specific hours and services required.

✦ 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 member/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.

✦ Have signatures of participants agreeing to services (not just sign-in sheet).

ATTACHMENT 8 - RESIDENTIAL TREATMENT ONLY - not required for submission, but must be kept on file at provider site in member’s record

✦ 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 must 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
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 member.

**PLEASE NOTE**

Addendums are used when there is an amendment (increase, decrease, or change in number of days 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.

Providers may request an addendum up to the last covered day. If seeking a change in services after the last covered day, the provider must submit a new continuation request.

**TIMELINES FOR AUTHORIZATION OF CHILDREN’S SERVICES**

Requests for continued BHRS must be submitted no earlier than 30 calendar days. Requests for continued RTF and CRR-HH must be submitted no earlier than 21 calendar days. 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. All attempts to engage parents in this process must be documented in the clinical record.

**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 request 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 it’s 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 clinical record.
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?

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 clinical record.

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 code of ethics of the psychology profession 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. Certain tests are approved for use by psychiatrists and these will be considered.

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 CBE’s, 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 when the request clearly indicates how testing will inform the behavioral health treatment plan. Extended evaluations (more than 4 hours) will be considered if indicated to inform the case conceptualization and behavioral health treatment plan. The extended evaluation must utilize diagnostic instruments and structured assessments tools targeted to specific evaluation questions generated by the CBE. The instruments chosen must be appropriate for the person being evaluated (normative data is based on the same population, appropriate to the age requirements, etc.).

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 client’s HMO.
- Requests in support of educational services should be directed to the client’s School District.
- Requests in support of vocational services should be directed to the PA Office of Vocational Rehabilitation.
- Requests in support of Intellectual disability case management or services should be directed to the Intellectual disAbility Services.

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 Director of Psychology, CBH, 801 Market Street, 7th Floor, Philadelphia, PA 19107; Fax: (215) 413-7184. 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 an appropriately qualified and supervised non-licensed doctoral level psychology student, intern or post-doctoral fellow in accordance with Section VIII, Clinical Supervision, of the CBH Credentialing Policy and Procedures Manual. Ideally, the psychologist participates on the client’s treatment team but at a minimum must provide feedback to the treatment team.

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 must document 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 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.

**Authorizations Guidelines for Out-of-Network 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 members temporarily residing outside of Philadelphia County.

It is important to understand that while a provider may recommend that a CBH member is in need of treatment services not available in the network, only CBH can authorize treatment of a CBH member 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-Based Services**

Providers may obtain a range of community support services on behalf of CBH members. The community based services listed below are authorized and coordinated by the Philadelphia County Office of Mental Health (OMH). To obtain prior authorization, call **(215) 599-2150**. 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 chronic homelessness and frequent 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. The service is accessible 24/7 and supported with active street outreach efforts. Frequency of contact can range from
multiple times in a day to once every 14 days.

**RESOURCE COORDINATION (RC):** A short-term service for persons with a major mental illness who may also have minor substance abuse issues and mild to moderate difficulty in accessing mental health treatment, social, job-related or daily living skills. Resource Coordinators will meet with individuals on a regular basis as dictated by their Personal Goal Plan. Frequency of contact may range from daily to every 30 days. Services are available Monday-Friday, 9:00 am - 5:00 pm.

**BLENDED CASE MANAGEMENT (BCM):** BCM is for persons with a major mental illness who may also have significant substance abuse problems. BCM is recommended for persons who experience frequent hospitalizations or times of crisis. These individuals may be unable to obtain or maintain community based MH treatment or to identify, reach, and maintain personal goals. The service is accessible 24/7. Frequency of contact can range from daily to once every 30 days based on individual need and their Personal Goal Plan.

**BLENDED ENHANCED CASE MANAGEMENT (TCM):** TCM is for persons with a severe and persistent mental illness who may also have serious substance abuse problems and/or additional issues. TCM is recommended for individuals who experience frequent hospitalizations, CRC visits and mobile emergency services. These programs are enhanced with a full-time psychiatrist, nurse and AOD specialist to support the needs of certain individuals on the caseload. These teams have extended office hours during the week and limited active work hours over the weekends. The service is accessible 24/7. Frequency of contact can range from multiple times a day to every 14 days depending on the individual’s Personal Goal Plan.

**ASSERTIVE COMMUNITY TREATMENT (ACT):** ACT is a service delivery model for providing comprehensive community based treatment to persons with serious mental illness who may also have serious substance abuse problems and/or other comorbid issues. It is a level of care that is used when several other types of community based treatment has been tried but not been effective and there have been several inpatient admissions. It is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who works as a team to provide the majority of treatment, rehabilitation, and support services individuals need to achieve their goals.

**CRISIS RESIDENCES (CR):** CR provide short-term residence options in a community setting for persons in crisis. Call (215) 413-7171.

**Ethanol(Alcohol) Testing**

According to the following clinical documents (SAMHSA TIP Series; TIP 47, Substance Abuse: Clinical Issues in Intensive Outpatient, pp. 242-244; 2006 SAMHSA TIP Series; TIP 43, Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, p. 144; 2008) testing for alcohol, outside of the use of a breath alcohol test, is typically not medically necessary for the assessment and treatment of substance use disorders. In the event that a provider believes that there is a clinical need for a test other than a breath alcohol test in an individual case, the provider may contact CBH to request prior authorization for the test. The determination whether a test other than a breath alcohol test is medically necessary will take into account the following:
Here 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 Partial Hospitalization programs
- all Intensive Outpatient Provider (IOP) services
- all emergency psychiatric evaluations

The provider should request an authorization number shortly after the episode of treatments begins but no later than 30 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 30 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 30 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 Psychiatric Consultations in Medical Facilities**

Providers are reimbursed for one initial and one follow-up consultation.

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

If a service recipient has been in a Nursing Facility for thirty (30) consecutive days or longer they are no longer CBH eligible.

Psychiatric consultations are to be performed ONLY by licensed psychiatrists or groups of psychiatrists who are independently credentialed by CBH.

Each type of consultation has a distinct BAN which must be used in billing.

CPT codes are time specific and therefore must contain a start and end time for the consultation.

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 CBE's
- all methadone maintenance clinic services
- all consultations
- all assessments
- Crisis Response Center (CRC) evaluations

Guidelines for 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 member 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
member’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 clinician who engaged in the clinical activities during that unit must also legibly sign the CBE/CBR.

While the CBE occurs 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.

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](image)

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. Consult the Utilization Management Guide for clinical information required to request continued authorization.

- **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 45 days of service provision.

The Care Management staff at DBH/CBH assesses 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 member’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 member (as well as staff) and the continuity of care and support. The following are types of discharges that can take place:

1. **Successful Completion of Treatment**

Member 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.

2. **Medical Leave**

Member 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.

**Guidelines for Coverage of Children in Residential Treatment Programs Requiring 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 hospitalizations.
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 accept the child back into treatment 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.

3 Therapeutic Leave

Clients in RTFs often receive therapeutic leave passes which provide opportunities for them to return briefly to their home/community while continuing treatment at the RTF. Therapeutic leave passes allow clients to become more familiar with utilizing skills learned in RTF outside of the residential setting.

A description of therapeutic leave guidelines and expectations are listed below (as excerpted from the Department of Public Welfare Medical Assistance Bulletin 01-95-13). The guidelines apply to both JCAHO and Non-JCAHO facilities:
Therapeutic leave is a period of absence from an institutional setting directly related to the treatment of the individual’s illness. The therapeutic leave must be prescribed as a part of the child’s individual treatment program. It is to be used as part of a professionally developed and supervised individual plan of care designed to achieve the child’s discharge from the facility and return to the community at the earliest possible time. The RTF where the child is currently receiving treatment is responsible both clinically and fiscally for mental health services the child may require while on leave.

The first day of therapeutic leave is defined as 12 to 24 hours of continuous absence from the facility, without staff presence, for therapeutic reasons, without regard to calendar day. Continuous absence for any portion of each additional 24-hour period for therapeutic reasons counts as an additional day of therapeutic leave. For example, if a child leaves the facility on therapeutic leave at 8 p.m. on Friday evening and returns at 3 p.m. on Saturday, the child has been out of the facility for 19 hours. Since 12 to 24 hours equals the first day of therapeutic leave, the child has used one day of therapeutic leave even though the child has been out of the facility on two different calendar days. Similarly, if the child leaves the facility at 10 a.m. on Saturday and returns 9 p.m. on Saturday, the child has been out of the facility for 11 hours. Since the first day of therapeutic leave equals 12 to 24 hours, no therapeutic leave days have been used. If the child leaves the facility at 10 a.m. on Saturday and returns at 4 p.m. on Sunday, the child has been out of the facility for 30 hours. This equals two days of therapeutic leave, 10 a.m. Saturday to 10 a.m. Sunday and a portion of the next 24 hour period from 10 a.m. to 4 p.m. Sunday.

Medical assistance payment for therapeutic leave in an RTF is limited to a maximum of 48 days of therapeutic leave per patient per calendar year. The limit applies even if the child is in continuous or intermittent treatment at one or more RTFs during the calendar year. The facility is responsible for keeping written records of the therapeutic leave days used before admission and during the child’s stay in the facility. The RTF may not bill for therapeutic leave days in excess of the 48 day per calendar year limit. The limitation of 48 days does not prohibit additional therapeutic leave to be prescribed and used as appropriate. It does limit the days of therapeutic leave for which the Department will make payment.

The facility will continue to be eligible for a full per diem payment for each day the child is on documented therapeutic leave within the 48 day limitation. In order for therapeutic leave days to be compensable, documentation in the child’s medical record must include the physician’s or psychologist’s order for the therapeutic leave, a description of the desired outcome, the date and time the child went on therapeutic leave and when the child returned, as well as a written evaluation resulting from interviews with both the child and family or legal guardian after the leave period. The evaluation shall describe the treatment objectives of the leave and the outcomes. The facility must report therapeutic leave usage when requesting prior approval for continued stay.

The facility must reserve the residential facility bed while the child is on compensable therapeutic leave. The facility may not use the reserved bed for which payment is made by Office of Medical Assistance Programs.

4 Transfer to Another Level of Care

In many cases, members 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 member 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 member may move from a medically monitored residential program to an intensive outpatient program and recovery housing.
Against Medical or Facility Advice (AMA) or Absent Without Leave (AWOL)

A member 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 a DBH/CBH member (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 members 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 an AWOL or AMA incident:

1. **Report the incident by phone within 24 hours** to the CBH Crisis Line (215) 413-7171 and/or the assigned clinical care manager

   **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 on 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 that 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 MEMBERS IN D/A RESIDENTIAL REHABILITATION

HOSPITAL LEAVE PROCEDURES

The DBH/CBH Care Manager assigned to the non-hospital treatment program will review the clinical information during the member’s hospital stay. This will be completed with the treatment program staff member responsible for coordinating care while the member 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 member. Coordination activities must include the hospital and the DBH/CBH Care Manager and must be documented in the member’s case record at the residential rehabilitation facility.

If residential rehabilitation services continue to be clinically appropriate for the member upon discharge from the hospital, the facility must take the member back immediately upon discharge.

If the DBH/CBH Care Manager decides that the member’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 member (if applicable).

A drug and alcohol (D&A) assessment is not required for re-entry into the program.

When the member 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 member 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.)

6 Administrative Discharge

On occasion, members are administratively 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 members. In some cases, those administrative discharges may have been prevented or issues resolved with appropriate interventions and/or alternative options.

DBH/CBH POLICY REQUIREMENTS REGARDING ADMINISTRATIVE 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 member’s needs. DBH/CBH staff work to ensure that all members 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 administrative discharge criteria with members upon admission into treatment. DBH/CBH in no way condones or supports the administrative discharge of members without options or interventions being offered to the member. DBH/CBH treatment provider must not conduct administrative discharge proceedings without the involvement, consultation and review by a team that includes:

- the treatment provider
- medical director of the treatment facility
- CBH
This policy of consultation regarding administrative discharge applies to both in-plan services offered by CBH and supplemental benefits made available through DBHIDS and OAS. 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 DBHIDS and OAS, 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
- DBHIDS - Targeted Case Management Unit
- Behavioral Health Specialist 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 members 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 (DBHIDS and BHSI), and DBHIDS Housing Staff is to intervene, when appropriate, at the point that an administrative as well as voluntary discharge is being considered.

**ADMINISTRATIVE DISCHARGE PROCEDURES**

Administrative Discharges are classified as significant incidents. If a DBH/CBH member, whether an adult or child is administratively 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 members—those receiving in-plan services, as well as those receiving supplemental funding through the DBHIDS and OAS, including BHSI.

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

1. Report the Administrative 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 administrative 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.)
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 member’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 a 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 only if the denial is in reference to an emergent level of care (acute inpatient or detoxification) on an initial or concurrent request. 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 DBH/CBH treatment decision, a denial letter will be generated.

For all other levels of care, once a denial letter is generated the provider can continue to provide this level of care and submit a clinical appeal within ninety (90) days of discharge. Additionally, for all levels of care, members and/or legal guardians may file a grievance following notification of the denial (see Grievance Process below).

For inpatient denials, a peer review is not required (see Provider Bulletin 09-05).

Denial of Services Notification

CBH members requesting or receiving services will be notified in writing when services have been denied so that they may have the right to file a grievance. 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 member 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 member the denial letter.

- The provider is expected to document clearly in the chart that the denial letter was given to the CBH member. The documentation must include date and time of receipt.

- It is expected that the provider will assist the CBH member in grieving the decision, with the written consent of the member, if the member so desires. This is not intended to assist providers in appealing decisions based on reimbursement, but to provide CBH members the right to grieve decisions that further deny treatment.

- For denials of BHRS and residential treatment services, letters are mailed directly to the member and family, and a notification of denial of services is sent to providers.

**GRIEVANCE PROCESS**

For information regarding the grievance process. Please review the Quality Management section (pages 5.3 through 5.4).

**PHYSICIAN REVIEW**

- A provider may request a physician review when an emergent level of care (acute inpatient or detox) is denied. This review would occur with the denying CBH physician and must occur within 24 hours.

**Clinical Appeals Procedure**

Appeals can occur at three (3) levels. **Providers may submit an appeal in writing to request retrospective reimbursement for days of service not authorized.**

**FIRST LEVEL APPEAL: CLINICAL APPEALS SPECIALIST**

**Step 1:** All first (1st) level appeal requests must be submitted no more than ninety (90) days after the last day of the episode of care in question.

**Step 2:** The appeal packet must include:

- **Cover letter:** including name/contact information for the person submitting the appeal, exact level of care being requested, exact dates of service in question, and a brief reason as to why the appeal is being submitted. The cover letter should be addressed to:
Clinical Appeals Specialist
801 Market Street
7th Floor
Philadelphia, PA 19107

- All documentation related to the dates in question: including evaluation, assessments, progress notes, etc.

Step 3: The Appeals Specialist will review the case. The Appeals Specialist will determine if the case warrants an:

- **Administrative Review** - meaning the provider did not adhere to CBH protocols or the case involves a clerical error.

  OR

- **Physician Review** - meaning the dates in question were denied by a CBH physician and the case needs to be reviewed by another CBH physician.

Step 4: CBH will notify providers of the result of their level appeal in writing within thirty (30) days of the receipt of the appeal request. If the dates in question are denied due to a clinical review, the provider may submit a second (2nd) level appeal. Instructions on how to submit this 2nd level appeal will be provided within the response letter. Please keep in mind a provider can not seek a 2nd level appeal if the 1st level appeal was denied due to an administrative review.

SECOND LEVEL APPEAL: CBH CHIEF MEDICAL OFFICER

In the event the provider disagrees with the 1st level appeal decision, the provider may request a 2nd level appeal.

Step 1: All 2nd level appeals must be submitted no more than 30 days from the receipt of the 1st level appeal response letter. Re-submission of the clinical information is not necessary.

Step 2: All 2nd level appeals should be addressed to:

Community Behavioral Health
Chief Medical Officer
801 Market Street
7th Floor
Philadelphia, PA 19107

Step 3: The CBH Chief Medical Officer or designee will review the clinical information and inform the provider of the decision in writing within thirty (30) days from the receipt of the 2nd level appeal. If the denial of the 1st level appeal is upheld, the provider may submit a third (3rd) level appeal. Instructions on how to submit this 3rd level appeal will be provided within the response letter.
THIRD LEVEL APPEAL: DBH/IDS MEDICAL DIRECTOR

In the event the provider disagrees with the 2nd level appeal decision, the provider may request a 3rd level appeal.

**Step 1:** All 3rd level appeal requests must be submitted no more than thirty (30) days from the receipt of the 1st level appeal response letter.

**Step 2:** All 3rd level appeals should be addressed to:

Department of Behavioral Health and Intellectual disAbility Services  
Medical Director  
1101 Market Street  
7th Floor  
Philadelphia, PA  19107

**Step 3:** The provider will be notified in writing of the results of the 3rd level appeal within fifteen (15) days of receipt of the 3rd level appeal request.

**Step 4:** The decision of the 3rd level appeal reviewer is final.

Resolving Disagreements about Authorizations

**Procedure for Services that Require Prior Approval**

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 3.3 for a listing of services.

For services that require prior approval, the provider must contact the assigned Care Manager to resolve any discrepancies no more than 30 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 60 days after the date of service or to the Clinical Appeals Specialist 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 Operations Support Services Coordinator within 45 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.

Requests for authorizations that are more than 45 days after the date of service must be submitted to the Chief Operating Officer. 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.
<table>
<thead>
<tr>
<th>CODE</th>
<th>ADULT MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td><strong>ADULT TARGET POPULATION #1:</strong> Administrative committed anytime in the last year <strong>OR</strong> a Dx in range of 295.xx, 296.xx, 298.9x, or 301.83 <strong>AND</strong> any of the following:</td>
</tr>
<tr>
<td></td>
<td>▶ Current residence or discharge from a state mental hospital within last 2 years</td>
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<tr>
<td></td>
<td>▶ Two admissions to community inpatient psychiatric units or correctional inpatient units or residential services totaling 20 or more days in the last 2 years</td>
</tr>
<tr>
<td></td>
<td>▶ Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years</td>
</tr>
<tr>
<td></td>
<td>▶ 1 or more years of continuous attendance in a community MH service (at least 1 unit per quarter)</td>
</tr>
<tr>
<td></td>
<td>▶ History of sporadic treatment - at least 3 missed appointments within the last 6 months, unwillingness to maintain meds regimen or administrative commitment to OP treatment</td>
</tr>
<tr>
<td></td>
<td>▶ 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</td>
</tr>
<tr>
<td></td>
<td>▶ Psychoactive substance use disorder</td>
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<td></td>
<td>▶ Mental Retardation</td>
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<td></td>
<td>▶ HIV/AIDS</td>
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<td></td>
<td>▶ Sensory, developmental and/or physical disability</td>
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<td></td>
<td>▶ Homelessness (sleeping in shelters, cars, parks, abandoned buildings, etc.)</td>
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<tr>
<td></td>
<td>▶ Release from criminal detention such as jail diversion, expiration of sentence or parole, probation or Accelerated Rehabilitation Decision (ARD)</td>
</tr>
<tr>
<td></td>
<td>▶ GAF below 51</td>
</tr>
<tr>
<td>4</td>
<td><strong>ADULT TARGET POPULATION #2:</strong> Diagnosis: Any diagnosable mental disorder, except the DSM &quot;V&quot; codes, substance abuse disorders and developmental disorders unless they occur with other serious mental illness</td>
</tr>
<tr>
<td></td>
<td>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.)</td>
</tr>
<tr>
<td>5</td>
<td><strong>ADULT TARGET POPULATION #3:</strong> Adults who are statutorily eligible for publicly funded MH services, but do not meet the criteria for Target Groups 1 or 2.</td>
</tr>
<tr>
<td>98</td>
<td><strong>NONE OF THE ABOVE, BUT RECEIVING MH SERVICES:</strong> Use this for members involved in the MH system who do not meet the above MH target group criteria, but are receiving MH services.</td>
</tr>
<tr>
<td>99</td>
<td><strong>NOT RECEIVING MH SERVICES:</strong> 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.</td>
</tr>
<tr>
<td>CODE</td>
<td>CHILD AND ADOLESCENT MENTAL HEALTH</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>54</td>
<td><strong>CHILD &amp; ADOLESCENT TARGET POPULATION #1:</strong> Administrative committed anytime in the last year OR MUST MEET ALL OF THE FOLLOWING CRITERIA:</td>
</tr>
<tr>
<td></td>
<td>▶ Age &lt; 18 (or &lt; 22, if in Special Ed) <strong>AND</strong></td>
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<tr>
<td></td>
<td>▶ Within the last year has had a DSM (except IDS or psychoactive substance use disorder) <strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td>▶ Receive services from any of the following:</td>
</tr>
<tr>
<td></td>
<td>‣ IDS</td>
</tr>
<tr>
<td></td>
<td>‣ Children and Youth</td>
</tr>
<tr>
<td></td>
<td>‣ Special Ed ‣ Juvenile Justice</td>
</tr>
<tr>
<td></td>
<td>‣ Health (the child has a chronic health condition requiring treatment) <strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td>▶ Identified as needing MH services by an interagency team, e.g. CASSP committee, Cordero Workgroup</td>
</tr>
<tr>
<td>55</td>
<td><strong>CHILD &amp; ADOLESCENT TARGET POPULATION #2:</strong> Children at risk of developing a serious emotional disturbance by virtue of any of the following:</td>
</tr>
<tr>
<td></td>
<td>▶ A parent's serious mental illness <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>▶ Physical or sexual abuse <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>▶ Drug dependency <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>▶ Homelessness <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>▶ Referral to the Student Assistance Program</td>
</tr>
<tr>
<td>56</td>
<td><strong>CHILD &amp; ADOLESCENT TARGET POPULATION #3:</strong> Children and Adolescents who have had a diagnosible mental illness in the last year (excluding IDS, D &amp; A or &quot;V&quot; 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.</td>
</tr>
<tr>
<td>98</td>
<td><strong>NONE OF THE ABOVE, BUT RECEIVING MH SERVICES:</strong> Use this for members involved in the MH system who do not meet the above MH target group criteria, but are receiving MH services.</td>
</tr>
<tr>
<td>99</td>
<td><strong>NOT RECEIVING MH SERVICES:</strong> 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>DRUG AND ALCOHOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td><strong>D&amp;A - PREGNANT WOMEN AND WOMEN WITH CHILDREN</strong></td>
</tr>
<tr>
<td>61</td>
<td><strong>D&amp;A - INTRAVENOUS DRUG USERS</strong></td>
</tr>
<tr>
<td>62</td>
<td><strong>D&amp;A - CHILDREN &amp; ADOLESCENTS YOUNGER THAN 18</strong></td>
</tr>
<tr>
<td>63</td>
<td><strong>D&amp;A - THOSE WITH SEVERE MEDICAL CONDITIONS (AIDS, TB, ETC.)</strong></td>
</tr>
<tr>
<td>64</td>
<td><strong>D&amp;A - NONE OF THE ABOVE, BUT RECEIVING D&amp;A SERVICES:</strong> Use this for members involved in the D&amp;A system who do not meet any of the above D&amp;A target group criteria, but receive D&amp;A services.</td>
</tr>
<tr>
<td>65</td>
<td><strong>D&amp;A - NOT RECEIVING D&amp;A SERVICES:</strong> Use this for members involved in the D&amp;A system who do not meet any of the above D&amp;A target group criteria, and do not receive D&amp;A services.</td>
</tr>
</tbody>
</table>
Date: __________________________

To: CBH Clinical Management - BHRS Team

From: Contact Person _______________________________
Agency _______________________________ CBH Provider # __________________
Phone _______________________________ Fax _______________________________
Fax ________________________________

Re: Child/Adelescent 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:

__________________________________________________________________________

__________________________________________________________________________

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__________________________________________________________________________

__________________________________________________________________________
ADOLESCENT ASAM SUMMARY FORM

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

Date ____________________________  Member DOB__________________Age________________
Provider_________________________  Provider # ____________________________
Therapist_________________________  Telephone ____________________________
Member 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 __________________________________________________________________________

Member's Substance Abuse History (for initial assessment only):

<table>
<thead>
<tr>
<th>Substance</th>
<th>Age of First Use</th>
<th>Amount/Method</th>
<th>Frequency Use</th>
<th>Date of Last Use</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

II. Adolescent ASAM Assessment

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

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

3. Please describe the member's emotional and behavioral condition. Please include information on previous psychiatric treatment.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
4. Please describe the member’s level of acceptance/resistance to treatment. What are the member’s motivational factors?

__________________________________________________________________________________________________________________________________________________________________

5. Please describe the member’s potential for relapse/continued use. What is the member’s understanding of relapse? How has the member responded to relapse prevention trainings?

__________________________________________________________________________________________________________________________________________________________________

6. Please describe the member’s home environment in terms of support for recovery. Please include information on member’s social support system.

__________________________________________________________________________________________________________________________________________________________________

III. Family Behavioral Health History

Please check the type of issues found in patient’s family history: □ D/A □ MH □ IDS □ 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: □ 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

Accessor 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. Please submit the most recent Comprehensive Biopsychosocial Evaluation (CBE) with this request. Be sure that the CBE includes a description of what other psychological testing has been conducted or requested (e.g., neuropsychological, psychoeducational, or vocational). Why has the CBE (attached) been insufficient to determine an initial case formulation and treatment plan?
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Page 1 of 2
4. Below, please list the complete names of tests that will be used to answer the above questions, the administration/scoring/interpretation time for each (give rationale for any that differ significantly from publisher recommended times), and its purpose.

<table>
<thead>
<tr>
<th>Name of Test</th>
<th>Time in Hours</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________</td>
<td>______________</td>
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</tbody>
</table>

Licensed Psychologist: Print Name __________________________

PA License # __________________________ Sign Name __________________________

CBH USE ONLY

Date Received ____________________________ Received by ____________________________

Authorization Approved ☐ Yes , # of Units ____________ Service Code ________________

☐ No Authorization # ____________________________

Comment: __________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

CBH Agent Name ________________________________________________________________ Date ____________________________

Date Copy Returned to Requester ____________________________ Returned by ____________________________
### CBH Intensive Outpatient (D&A) Service Request Form

**Type of Service:** D&A IOP  
**Date of Submission:** 6/18/2001

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Provider Contact</th>
<th>Provider Fax</th>
<th>Authorizations</th>
<th>Date CBH Received</th>
</tr>
</thead>
</table>

| Group Code | Primary Axis | Dx | Primary Sec. Axis | Dx | Primary Team | Dx | Primary Voc. Code | Dx | Primary Living Arrangement Code | Dx | Primary Sec. Axis | Dx | Primary Priority | Dx | Primary Code | Dx | Primary Venue | Dx | Primary Authorization Code | Dx | Primary Authorization | Dx | Primary Authorization | Dx | Primary Authorization | Dx | Primary Authorization |
|------------|--------------|----|------------------|----|-------------|----|-----------------|----|-------------------|----|-----------------|----|------------------|----|-----------------|----|-----------------|----|-----------------|----|-----------------|----|-----------------|----|-----------------|----|-----------------|----|-----------------|

**Requested Service Code for IOP:**  
**Initial Service Start Date:**  
**Requested Service Start Date:**  
**Requested Service End Date:**  
**# of Units (Hours Per Week):**  
**Primary Axis I Dx:**  
**Secondary Axis IDx:**  
**Priority Group Code:**  

---

**Provider Number:**  
**Date CBH Received:**  

---

**Type of Service:** D&A IOP
**PHILADELPHIA DEPARTMENT OF BEHAVIORAL HEALTH**

**SIGNIFICANT INCIDENT REPORT**

Fax to Department of Behavioral Health (DBH) at 215-413-7132 within 24 hours

<table>
<thead>
<tr>
<th>1. Type of Service:</th>
<th>Adult - Mental Health</th>
<th>Adult - Substance Abuse</th>
<th>Level:</th>
<th>Children's</th>
<th>Other</th>
<th>type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Location of Incident:</td>
<td>Residential</td>
<td>Outpt.</td>
<td>Inpatient</td>
<td>PHP</td>
<td>Other Day Program</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>(e.g. LTSR, RTF Level 1, etc.)</td>
<td>(e.g. clubhouse)</td>
<td>type (e.g. TCM, private residence)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Consumer/Client Name</td>
<td></td>
<td>4. Date of Birth</td>
<td>5. Date of Incident:</td>
<td>Time: am</td>
<td>pm</td>
<td></td>
</tr>
<tr>
<td>6. Provider #:</td>
<td></td>
<td>8. Name, Title, Address, Phone #:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Reporting Agency:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9. Agency/program where incident occurred (if other than above)</td>
<td></td>
<td>10. Location/address where incident occurred</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11. Other witnesses:</td>
<td></td>
<td></td>
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<tr>
<td>12. Indicate type of incident (Please check)</td>
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<tr>
<td></td>
<td></td>
<td>* Medical Intervention includes staff/facility nurse.</td>
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</tr>
<tr>
<td>☐ Death of a consumer/client.</td>
<td>☐ Neglect resulting in injury or hospital treatment (MH Only).</td>
<td>☐ Infectious disease outbreak at a provider site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Homicide committed by consumer/client who is receiving services or has been discharged within 30 days.</td>
<td>☐ Restraints (passive physical, mechanical, and chemical)</td>
<td>☐ Missing person: child who has not returned home or facility within 4 hours; at-risk adult who has not returned home within 24 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Suicide attempt</td>
<td>☐ Seclusion</td>
<td>☐ Any sexual contact involving a minor, consensual or otherwise.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Act of violence requiring medical intervention*, by or to a consumer (MH only, if by a consumer)</td>
<td>☐ Police involvement or arrest (excludes involuntary commitments – 302s)</td>
<td>☐ All non-routine discharges from inpatient, residential rehab (D&amp;A), children’s residential, detoxification, or methadone maintenance setting, i.e., administrative/involuntary discharges or leaving a facility against medical or facility advice (AMA, AFA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Alleged or suspected abuse (physical, sexual, financial) of or by a consumer/client</td>
<td>☐ Fire, flood, or serious property damage at a site where behavioral health services are delivered.</td>
<td>☐ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Adverse reaction to medication and/or medication error administered by a provider (MH Only)</td>
<td>☐ Any physical ailment or injury that requires medical attention at a hospital on an emergency, outpatient or inpatient basis.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

14. Describe any corrective actions taken to prevent reoccurrence:

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

15. Which of the following persons were notified by telephone?

<table>
<thead>
<tr>
<th>Person &amp; Phone #:</th>
<th>Person &amp; Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>Police</td>
</tr>
<tr>
<td>Family/Significant Other</td>
<td>Fire Dept.</td>
</tr>
<tr>
<td>Case Mgr.</td>
<td>DHS Childline</td>
</tr>
<tr>
<td>Community Tx. Team</td>
<td>BHSI</td>
</tr>
<tr>
<td>Mental Health Delegates</td>
<td>Other agency</td>
</tr>
</tbody>
</table>

16. Signature of person filing report: ___________________________ Date: ____________

_DBH: CBH PROVIDER MANUAL REV.2014_
<table>
<thead>
<tr>
<th>Client Name</th>
<th>CIS#</th>
<th>Auth #</th>
<th>Type of Service</th>
<th>Start/End Date</th>
<th>Start/End Hours</th>
<th>Start/End Units</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Reason Codes:
- a = Unit Shortage
- b = Excessive Units
- c = Incorrect Dates
- d = Incorrect Service
- e = Other (Please Comment)
ALCOHOL (ETHANOL) TESTING AUTHORIZATION REQUEST

(Please print legibly/type)

Member Name____________________________________________ Date of Request________________________________

MA CIS# ______________________________________  Date of Birth ____________________ Soc Sec#_________________

Agency Name ___________________________ CBH provider # ________________ Fax # ___________________

Physician Requesting Name _______________________________ Position/Title___________________ Phone# _________

Laboratory Name ___________________________________________________________ Phone #___________________

DSM Diagnoses (give complete diagnostic category name including specifiers, if relevant):

________________________________________________________________________________________________________

1. Amount of alcohol consumed daily? ___________________________________________________________

2. Date of last alcohol use? ________________________________________________________________________________

3. Please indicate clinical rationale as to why an alcohol breath test may not be utilized:

________________________________________________________________________________________________________

CBH USE ONLY

Date Received ____________________________ Received by ____________________________________________________

Comment: _______________________________________________________________________________________________

...........................................................................................................................................................................................................

Approved? □ Yes □ No