Outpatient Treatment Request

CPST, PSR and Permanent Supportive Housing 60 Day Authorization Period

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

Instructions

Submit these documents:

By fax to:

1-888-725-0101

- ☐ This Outpatient Treatment Request form
- ☐ LOCUS/CALOCUS Assessment (completed within last 180 days)
- ☐ Treatment Plan
- ☐ Healthy Louisiana Behavioral Health Assessment (annually)
- ☐ Complete all questions to prevent delay in processing and determination.
- ☐ Member Choice Form

This form is for CPST or PSR.
Renewal every 60 days may be requested using this form.

Provider Information

Clinician:_____ Credentials: _____

Agency Name:_____

Agency Phone:_____ Agency Secure Fax:_____

Agency NPI:_____ Agency TIN: _____

Agency Address:_____

City: _____ State: _____ Zip:_____

Member Information

First Name:_____ Last Name: _____

Member ID:_____ Date of Birth:_____

Member Diagnosis (Dx Code and Name):_____

Member Medical Diagnosis (Dx Code and Name):_____

Does member participate in Medication Management (check one): ☐ **YES** ☐ **NO**

Prescriber Name and Last Date seen by member:_____ _____

List of member's current medications with dosages:_____

_____

Agreement to Participate in Treatment

Did provider submit a Member Choice Form signed by all needed parties? □ **YES** □ **NO**

Date Member Choice Form was signed (MM/DD/YYYY):_____

Assessment

Date of the most recent Comprehensive Behavioral Health:_____

Date of the most recent CA/LOCUS Assessment and scores:_____

**Please submit most recent signed CA/LOCUS Assessment with this authorization request

Requested Authorization

Tip: Be sure to indicate the appropriate place of service code when you submit your claim.

PROCEDURE CODES (MODIFIERS ONLY FOR SUPPORTIVE HOUSING SERVICES)	SERVICE DATES MM/DD/YYYY	Frequency: HOW OFTEN SEEN	Intensity: # OF UNITS PER VISIT	TOTAL UNITS REQUESTED
Community Psychiatric Support Treatment ☐ H0036	Request Start: / Request End: *(Standard: 60 days)*			
Psychosocial Rehabilitative Services H2017 Individual Office or Community ☐ H2017 ☐ H2017 Permanent Supportive Housing	Request Start: / Request End: *(Standard: 60 days)*			

Risk Assessment

Member Risk History (Within past 12 calendar months)

	None	Mild Ideations only	Moderate Ideations with plan of attempts	Severe Ideations AND plan, with either intent or means	Not Assessed
To Self:	☐	☐	☐	☐	☐
To Others:	☐	☐	☐	☐	☐

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Current Member Risk (Within past 60 days)

	None	Mild Ideations only	Moderate Ideations with plan of attempts	Severe Ideations AND plan, w/ either intent or means	Not Assessed
To Self:	☐	☐	☐	☐	☐
To Others:	☐	☐	☐	☐	☐

Detail any past or current risk rated **moderate or severe**:

_____

_____

Crisis Management / Safety Plan

Does the member have a behavioral health crisis management or safety plan in place?

□ **YES** □ **NO**

If yes, what is the date of the most recent plan? _____

Has member received crisis intervention services in the last 60 days? □ **YES** □ **NO**

If YES, list dates crisis services were provided to member **and** describe crisis below (MM/DD/YYYY):

_____

_____

Evaluation and Treatment Planning

Has the member (or guardian) signed the Treatment Plan and agreed to participate? □ **YES** □ **NO**

TREATMENT GOALS	LIST ASSOCIATED SEVERE SYMPTOMS	PROGRESS TOWARDS MEETING GOALS: (RENEWAL ONLY)	BARRIERS TO MEETING GOALS: (RENEWAL ONLY)
Goal 1:			
Goal 2:			
Goal 3:			
Goal 4:			

Additional information related to goals, progress, and barriers:

_____

_____

FUNCTIONAL OUTCOMES (select yes or no)

In the last 30 days, has member received inpatient or residential behavioral health care?	☐ **YES**	☐ **NO**
In the last 30 days, has the member had problems with sleeping or feeling sad?	☐ **YES**	☐ **NO**
In the last 30 days, has the member had problems with had problems with fears and anxiety?	☐ **YES**	☐ **NO**
In the last 30 days, has alcohol or drug use caused problems for member?	☐ **YES**	☐ **NO**
In the last 30 days, has member gotten in trouble with the law?	☐ **YES**	☐ **NO**
In the last 30 days, has member had trouble getting along with other people including family and people out the home?	☐ **YES**	☐ **NO**
In the last 30 days, has member had an unstable living situation?	☐ **YES**	☐ **NO**

CHILDREN ONLY

In the last 30 days, has member been suspended or expelled from school?	☐ **YES**	☐ **NO**
Is member currently in state custody (DCFS or Juvenile Justice)?	☐ **YES**	☐ **NO**
Is member currently attending traditional school?	☐ **YES**	☐ **NO**

If NO, List school member attends (alternative school, homebound services, etc)

_____

ADULTS ONLY

Is member currently employed?	☐ **YES**	☐ **NO**
Is member currently in school?	☐ **YES**	☐ **NO**
Does member have stable housing?	☐ **YES**	☐ **NO**

SYMPTOMS (IF PRESENT, SELECT DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Inattention	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Social Withdrawal	☐	☐	☐	☐	Outbursts/Anger	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT (IF PRESENT, SELECT DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Personal Hygiene	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Medication Compliance	☐	☐	☐	☐	Relationships	☐	☐	☐	☐
Substance Use (Current)	☐	☐	☐	☐					

List Substance Used: _____

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Previous Treatment Service Coordination

Has member received **any previous behavioral health services** (inpatient or residential, substance use, counseling, medication management, assessment, etc…) □ **YES** □ **NO**

If yes, list services below with dates.

Services Received	Provider Name	Date Started	Date Ended

Does member participate in with any agencies that would require coordination of care (DCFS, CSOC, FINS, OJJ, probation, court, Wrap Around Agency, etc…) □ **YES** □ **NO**

If yes, list services below with dates.

Services Received	Contact Name	Date Started	Last Visit

If applicable, provide a summary of last meeting with agency above: _____

_____

_____

Discharge Planning

Have you discussed the discharge plan from the requested services with the member?
□ **YES** □ **NO**

Target discharge date from the requested services:_____

Additional Information:

Please provide any additional information to help support your request for medical necessity including any assessments that may have been completed.

_____

_____

_____

Member Attendance and Engagement (Renewal Requests Only)

Since the last outpatient treatment request, did the member attend and engage in the requested services?

❑ Fully (100%) ❑ Partially (70% - 99%) ❑ Poorly (50% - 69%) ❑ Did Not (0% - 50%)

If member did not fully participate, why not?

❑ Member had inpatient hospitalization

❑ Member was incarcerated

❑ Member with continued non-compliance to MHR treatment schedule (explain below)

❑ Other (explain hospitalization below):

_____

Explanation for poor participation, refusal of participation, MHR treatment schedule, or other reason(s) provider indicates member did not fully participate in treatment:

_____

_____

Attestation of Licensed Clinician (Required for ALL Requests)

It is important to the health outcomes of our members that licensed providers are actively engaged in the mental health rehabilitation services delivered under their supervision. The Louisiana Department of Health Behavioral Health Provider Manual also emphasizes the importance of active supervision by a licensed provider:

"The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health professional or physician, or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and restoration to his/her best age appropriate functional level."

By signing below, I, a licensed mental health clinician, attest that:

The LOCUS/CALOCUS assessment was completed by myself (or another licensed mental health clinician at my agency) face-to-face directly with the member, or in the case of a pre-verbal minor, face-to-face directly with the member's legal guardian.

The Treatment Plan was developed by myself (or another licensed mental health clinician at my agency), and the member has been determined to have the ability to participate in and benefit from this Treatment Plan.

I have determined the requested services are medically necessary and the contents of this Outpatient Treatment Request are true and accurate.

Clinician:_____ Signature:_____

License #:_____ Date:_____

NPI: _____