Outpatient Treatment Request Form

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

Member Information

First Name _____ (PLEASE PRINT) Last Name _____ (PLEASE PRINT)

Medicaid ID # _____ Date of Birth (mm/dd/yyyy) _____

Member Primary ICD-10 Diagnosis _____

_____

_____

Comorbid ICD-10 Medical Diagnosis _____

Provider Information

Evaluator's Name _____ (PLEASE PRINT) Credentials _____

Evaluator's Phone ( ) _____ Secure Fax ( ) _____

Provider/Agency NPI Sub Provider _____ Provider/Agency Tax ID # _____

Billing Address _____ City _____ State _____ Zip _____

Prior Outpatient Treatment Services

Member has previously received outpatient services?

☐ **YES** from this provider and/or agency

☐ **YES** from a different provider and/or agency

☐ **NO** prior history of outpatient mental health services

If YES, dates of services and type:

DATE	SERVICES (description and duration)

If YES, is this a CONTINUATION/EXTENSION REQUEST of a previous authorization?

☐ **YES** (If YES, Extension Request section must be completed) ☐ **NO**

Please continue to page 2.

Please submit the completed form to:

Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759

PHONE: **1-866-595-8133**
FAX: **1-844-466-1277**

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes assessment, etc.).

Assessment and Evaluation

Date of the current Developmental/Comprehensive Evaluation/Functional Behavioral Assessment: _____
PLEASE PRINT

** Results must be demonstrated in plan of care/treatment plan.*

(1) *The individual identified as the evaluator and whose signature is included on this form, attests that they are the clinician, meeting all necessary licensure requirements, who was directly responsible for the completion of all evaluations/assessments that have been utilized in submission of this request for outpatient treatment.* ☐ *YES* ☐ *NO*

(2) *The evaluations/assessments that have been utilized in submission of this request for outpatient treatment have been completed face-to-face, in person, directly between the member (and/or parent/legal guardian for infants and young children) and the evaluator.* ☐ *YES* ☐ *NO*

This LOCUS/CALOCUS is an ☐ **INITIAL** ☐ **UPDATE**	**Former LOCUS/CALOCUS Ratings BELOW** ☐ **A LOCUS/CALOCUS completed within 180 days has previously been submitted.** [3] Date of prior LOCUS/CALOCUS: _____	**Recent Progress Status** *(Goals Met* *Goals Improved* *Goals Unchanged* *Goals Regressed)*
Risk of Harm *(SI/HI/Command AH, risky behaviors, impulsivity)*		☐ **Goals Met** ☐ **Goals Improved** ☐ **Goals Unchanged** ☐ **Goals Regressed**
Impairment in Functional Status *(Self-care, fulfilling daily life roles, socialization and interpersonal deficits which is a change from baseline)*		☐ **Goals Met** ☐ **Goals Improved** ☐ **Goals Unchanged** ☐ **Goals Regressed**
Presence of Co-Morbidity *(Co-occurring physical health or substance abuse conditions)*		☐ **Goals Met** ☐ **Goals Improved** ☐ **Goals Unchanged** ☐ **Goals Regressed**
Environmental Factors *(Degree of life stressors with ability to cope effectively and degree of support or lack thereof)*		☐ **Goals Met** ☐ **Goals Improved** ☐ **Goals Unchanged** ☐ **Goals Regressed**
Engagement and Recovery Status *[Member's level of change and acceptance/responsibility of condition(s)]*		☐ **Goals Met** ☐ **Goals Improved** ☐ **Goals Unchanged** ☐ **Goals Regressed**

(3) *If a LOCUS/CALOCUS completed within the past 180 days has been submitted with a previous Outpatient Treatment Request, resubmission of that LOCUS/CALOCUS is not necessary with this submission.*

Please continue to page 3.

The following section is for a NEW/INITIAL request for Outpatient Treatment Services.

MEASURABLE TREATMENT GOALS
Treatment Goal 1:
Treatment Goal 2:
Treatment Goal 3:

Discharge Planning

Member is aware of current Discharge Plan?

☐ Yes
☐ No (Please explain): _____

Target Discharge Date from current level of services: _____

Is there mutual understanding of the termination of treatment?

☐ Yes
☐ No (If not, please explain why not): _____

TO COMPLETE INITIAL REQUEST, GO TO PAGE 5. FOR A RENEWAL/CONTINUATION, PLEASE CONTINUE.

Request for Continuation of Services (Level Of Improvement To Date)

During the past 30 days, did the member participate in the initially requested mental health service?

☐ Yes. Fully participated (100% compliance)
☐ Yes. Partially participated (70% - 99% compliance)
☐ Yes. Poor participation (50% - 69%)
☐ No. Did not actively participate (less than 50% participation)

If member did not FULLY participate, why:

☐ Member had inpatient hospitalization
☐ Member was incarcerated
☐ Member non-compliance with treatment plan
☐ Other (explain):

Member participated in medication management services during the past 30 days: ☐ Yes ☐ No

Current frequency of psychiatric visits: ☐ Weekly ☐ Every other week ☐ Monthly ☐ Other _____

Have there been changes to psychotropic medications since last review? ☐ Yes ☐ No

Is member adhering to medications as prescribed? ☐ Yes ☐ No

Member has signed treatment plan and agreed to participate in treatment? ☐ Yes ☐ No

Physician has signed treatment plan and has found plan medically necessary and determined that member has ability to participate in and benefit from treatment plan. ☐ Yes ☐ No

A copy of the treatment plan is attached to this Outpatient Treatment Request form? ☐ Yes ☐ No

Please continue to page 4.

Current Assessment & Progress Toward Measurable Treatment Goals Since Last Review

Treatment Goal 1:

Since last review, member has made the following progress toward Goal #1

- ☐ 100% goal attainment
- ☐ 80% - 99% goal attainment
- ☐ 60% - 79% goal attainment
- ☐ 40% - 59% goal attainmen
- ☐ 20% - 39% goal attainment
- ☐ 5% -19% goal attainment
- ☐ No progress made to date

Treatment Goal 2:

Since last review, member has made the following progress toward Goal #2

- ☐ 100% goal attainment
- ☐ 80% - 99% goal attainment
- ☐ 60% - 79% goal attainment
- ☐ 40% - 59% goal attainmen
- ☐ 20% - 39% goal attainment
- ☐ 5% -19% goal attainment
- ☐ No progress made to date

Treatment Goal 3:

Since last review, member has made the following progress toward Goal #3

- ☐ 100% goal attainment
- ☐ 80% - 99% goal attainment
- ☐ 60% - 79% goal attainment
- ☐ 40% - 59% goal attainmen
- ☐ 20% - 39% goal attainment
- ☐ 5% -19% goal attainment
- ☐ No progress made to date

Member is following all treatment recommendations? ☐ Yes ☐ No (If no, explain below)

Member is a risk to self:

- ☐ None
- ☐ Mild, ideations only
- ☐ Moderate, ideations with EITHER plan or history of attempts
- ☐ Severe, ideations AND plan, w/either intent or means
- ☐ NOT ASSESSED

Member is a risk to others:

- ☐ None
- ☐ Mild, ideations only
- ☐ Moderate, ideations with EITHER plan or history of attempts
- ☐ Severe, ideations AND plan, w/either intent or means
- ☐ NOT ASSESSED

Member has a behavioral health crisis management or safety plan in place:

- ☐ No
- ☐ Unknown
- ☐ Yes (date of most recent plan: _____)

Please continue to page 5.

Discharge Planning

Member is aware of current discharge plan? ☐ Yes ☐ No (If no, explain below)

Target discharge date from current level of services: _____

Is there mutual understanding of the termination of treatment? ☐ Yes ☐ No (If no, explain below)

Treatment Duration & Service Delivery

Has member received this level of treatment ongoing for more than:

- ☐ 3 months
- ☐ 6 months
- ☐ 9 months
- ☐ 12 months
- ☐ 18 months
- ☐ 24 months or longer

Member receives Mental Health Services in the following locations *(check all that apply)*:

- ☐ Outpatient clinic
- ☐ Community clubhouse
- ☐ Member's home
- ☐ School site (Ensure IEP is attached)
- ☐ General community

If additional services are being requested for Homebuilders, the Homebuilder's consultant has approved the requested continuation of services: ☐ Yes *(approval attached)* ☐ No

THE FOLLOWING SECTION IS FOR INITIAL AND CONTINUED REQUEST FOR SERVICES

Requested Authorization *(Please check appropriate box to indicate modifier, if applicable.)*

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # OF UNITS PER VISIT	REQUESTED START DATE FOR AUTH.	TOTAL UNITS REQUESTED FOR CODE FOR THIS AUTHORIZATION PERIOD
ALL OUT-OF-NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING					
Behavioral Health Outpatient Services (billed with CPT Codes) ☐ **Individual Therapy** ☐ **Goup Therapy** ☐ **Family Therapy**					
Alcohol and/or Drug Services ☐ **H0011** ☐ **H0012** ☐ **H0014**					
Respite Care (No authorization requirement for 7 days. After 7 days, authorization is required.) ☐ **H0045 HA** ☐ **S9125**					

Please continue to page 6.

Requested Authorization (continued from page 5)

(Please check appropriate box to indicate modifier, if applicable.)

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # OF UNITS PER VISIT	REQUESTED START DATE FOR AUTH	TOTAL UNITS REQUESTED FOR CODE FOR THIS AUTHORIZATION PERIOD
ALL OUT-OF-NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING					
Community Psychiatric Support ☐ Treatment H0036 HO/HN/HM ☐ H0036 HO/HN (Homebuilders) ☐ H0036 HE Functional Family Therapy (FFT)					
Assertive Community Treatment Program(ACT) ☐ H0039					
Psychiatric Health Facility Service, per diem ☐ H2013					
Psychosocial Rehabilitative Services H2017 Individual Office ☐ H2017 HA/HQ child/adolescent program, office group ☐ H2017 HA/HQ child/adolescent program, group place of service. 11 or 53 for home and community. ☐ H2017 HB/HQ adult program, non-geriatric, office group. ☐ H2017 HB/HQ adult program, non-geriatric group place of service. 11 or 53 for home and community. ☐ H2017 TG (PSR) ☐ H2017 TG/U8 (PSR)					
Foster Care, Therapeutic, Child, per diem ☐ S5145					
PRIOR AUTHORIZATION FOR PSYCHOTHERAPY CODES (EXCESS OF 12 SESSIONS IN A CALENDAR YEAR BY A SINGLE PROVIDER)					
PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # OF UNITS PER VISIT	REQUESTED START DATE FOR AUTH	TOTAL UNITS REQUESTED FOR CODE FOR THIS AUTHORIZATION PERIOD
☐ 90832 Psychotherapy 30 min. with patient and/or family member					
☐ 90833* Psychotherapy 30 min. with patient with patient and/or family member when performed with an E/M service					

Please continue to page 7.

Requested Authorization (continued from page 6)

(Please check appropriate box to indicate modifier, if applicable.)

PRIOR AUTHORIZATION FOR PSYCHOTHERAPY CODES (EXCESS OF 12 SESSIONS IN A CALENDAR YEAR BY A SINGLE PROVIDER)					
PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # OF UNITS PER VISIT	REQUESTED START DATE FOR AUTH	TOTAL UNITS REQUESTED FOR CODE FOR THIS AUTHORIZATION PERIOD
☐ **90834 Psychotherapy** 45 min. with patient and/or family member					
☐ **90836* Psychotherapy** 45 min. with patient and/or family member when performed with an E/M service					
☐ **90837 Psychotherapy** 60 min. with patient and/or family member					
☐ **90838* Psychotherapy** 60 min. with patient and/or family member when performed with an E/M service					
☐ **90840 Psychotherapy for Crisis** each additional 30 min					
☐ **90847 Family Psychotherapy** conjoint psychotherapy; with patient present					
☐ **90849 Multiple Family Group Psychotherapy**					
☐ **90853 Group Psychotherapy** other than of a multiple family group					
☐ **90845 Psychoanalysis**					
☐ **90875 Individual Therapy with Biofeedback—** 30 min					
☐ **90876 Individual Therapy with Biofeedback—** 60 min					
* *If this add-on code is billed with any other service, that visit will count towards the 12 visits.*					

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Please continue to page 8.

Additional information:

*** Please Note: You MUST INCLUDE this Outpatient Treatment Request (OTR) Form for all Subsequent Requests.

The lack of document submission could possibly result in a call out to the provider for further clinical information and/or result in a peer review.

Please attach the accurate and current reflection of member's functional state LOCUS / CALOCUS completed within the last 180 days. Additionally, please attach the most recent plan of care. By signing and including for review, I hereby attest that I, ***a licensed mental health practitioner allowable to complete the assessment***, have appropriately done so. All assessments and evaluations completed have occurred in person, face-to-face, directly with the member identified on page one (1) of this request, unless otherwise indicated below:

- ☐ The assessment/evaluation was conducted face-to-face, directly with the Member identified on page 1.
- ☐ The assessment/evaluation was conducted face-to-face, directly with the:
  - ☐ Member's Mother
  - ☐ Member's Father
  - ☐ Member's Legal Guardian
  - ☐ Member's Foster Parent/Caretaker

  Because:
  - ☐ Member is an infant/pre-verbal child AGE _____

  Member:
  - ☐ **Was** present for the evaluation
  - ☐ **Was not** present for the evaluation

CLINICIAN PRINTED NAME	DATE	CLINICIAN SIGNATURE & LICENSURE	DATE

Provider NPI: _____

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PHONE: 1-866-595-8133 | FAX: 1-844-466-1277

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, assessment, etc.).