Community Rehabilitative Services Request Form Overview

Instructions for Service Requests:

In Section III, complete each column for the applicable service:

1. Select the service(s) and code(s) being requested
2. Identify the reason for the request (see definitions below). Select all that apply.
3. Identify the number of units for the request.
4. Provide the requested start date or dates of service.

Reason for Request:

Day 1 Authorization Required: Authorization is required prior to rendering this service

Service threshold met: Client is already receiving service and is nearing or has met the initial threshold OR member has exhausted previously authorized units.

Exceeds daily limit: Client requires an amount of service that exceeds the daily limit set for that particular service.

Same Day Services (Adults Only):

- An authorization is required for a client to receive same day group service for more than 1 hour (cumulative) on the same day as H2012 TBS Day Tx hourly, H2020 TBS Day Tx per diem, H0015 IOP, H0015TG PHP. Prior authorization is also required to receive reimbursement for IOP/PHP and TBS Day Treatment per diem or hourly, when delivered to one Medicaid member on the same day, whether by a different or the same provider.
- In general, when you add a second group service, that is the service that will require a same day authorization. The documentation on the form should demonstrate the necessity of the new group service in addition to the group service the client is already receiving. A follow up authorization may also be required for additional units of either service.
- When requesting a community BH Rehabilitative group service to be billed on the same day as an SUD service, utilize the Community Behavioral Health Rehabilitative Services Authorization Request. When requesting an SUD group service on the same day as a TBS Day Treatment Per Diem/Hourly, utilize the SUD ASAM LOC Authorization Form.

THRESHOLDS FOR SERVICES REQUIRING AN AUTHORIZATION

SERVICE	Code	Service Threshold
Alcohol/Drug Assessment	H0001	2 assessments per patient per calendar year per billing agency
Assertive Community Treatment	H0040	ACT must be prior authorized 1x/year and SUD services above ASAM level 1 must be prior authorized for ACT enrollees.
Psychological / Neuropsychological Testing	96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137	Up to 12 hours per patient per calendar year for psychological testing codes. Up to 8 hours per patient per calendar year for neuropsychological testing codes.
SBIRT Services	G0396, G0397	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95
Psychiatric Diagnostic Evaluation	90791, 90792	1 encounter per person per calendar year per code per billing agency for 90791 and 90792.
TBS Individual	H2019	200 units (50hrs) combined TBS or PSR per calendar year
TBS Group	H2019 HQ	120 units (30hrs) per calendar year, same day service
Peer Support	H0038	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached
Peer Support Group	H0038 HQ	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached. Authorization also needed if provided as a same day service
CPST Individual	H0036	200 units (50hrs) per calendar year
CPST Group	H0036 HQ	120 units (30hrs) per calendar year, same day service
PSR	H2017	200 units (50hrs) combined TBS or PSR per calendar year
Group Psychotherapy	90853	Authorization is needed if provided as a same day service
TBS Day Treatment Hourly	H2012	Authorization is needed if provided as a same day service
TBS Day Treatment (Per Diem)	H2020	After 30 units per calendar year, same day service

Ohio Department of Medicaid

Community Behavioral Health Rehabilitative Services

Authorization Request

Instructions
The following information should be submitted to the MCE as an attachment to this form: • Include service start date and referral source along with reason for services • Attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service. • Provide primary/secondary diagnoses and psychosocial issues/barriers to treatment • Provide pertinent medical and BH history including suicidal ideation/homicidal ideation risk • Provide treatment plan with target dates and discharge plan • For continued stay requests please provide: any new problems identified, an update on the treatment plan including how lack of progress is being addressed in any areas, updated discharge plan, and updated information on psychosocial barriers. Requests for Substance Use Disorder (SUD) Residential Treatment, SUD Intensive Outpatient, SUD Partial Hospitalization and Withdrawal Management should be submitted using the ODM 10276 “Substance Use Disorder Services Prior Authorization Request” form. *If H2012 or H2020 is to be provided on the same day as H0015 or H0015TG or more than one hour of H0005, providers must ensure ODM SUD Authorization Request Form has been submitted and approved in addition to this request.*

Section I: Member Information	
Managed Care Plan:	**Date of Request:**
Member Name:	**Date of Birth:**
Member ID Number:	**Member Phone:**
Requested Authorization Decision Type ☐ Standard ☐ Expedited	

Section II: Provider Information	
Organizational Billing Provider/Agency Name:	**Service Location Address:**
Organizational Billing Provider/Agency NPI:	**Provider / Agency Tax ID:**
Contact Name:	**Phone Number:**
Email Address:	**Fax Number:**
Practitioner’s Name and Credentials:	**Practitioner NPI:**
Network Status with Managed Care Plan, if applicable ☐Participating ☐Non-Participating	

Section III: Service(s) Requested

Description	Reason For Request	Units/Visits Requested	Requested Start Date or Dates of Service
Alcohol and Drug Assessment ☐H0001	☐ Service threshold met		
Assertive Community Treatment ☐H0040	☐ Initial or reauthorization		
Psychological / Neuropsychological Testing ☐96130 ☐96131 ☐96136 ☐96137 ☐96132 ☐96133 ☐96112 ☐96113 ☐96116 ☐96121	☐ Service threshold met		
SBIRT Services ☐G0396 ☐G0397	☐ Service threshold met		

Psychiatric Diagnostic Evaluation ☐90791 ☐90792	☐ Service threshold met		
Peer Support ☐H0038 ☐H0038 HQ	☐ Exceeds daily limit ☐ Same day services		
*TBS Individual ☐H2019	☐ Service threshold met		
*TBS Group ☐H2019 HQ	☐ Service threshold met ☐ Same day services		
*CPST Individual ☐H0036	☐ Service threshold met		
*CPST Group ☐H0036 HQ	☐ Service threshold met ☐ Same day services		
*PSR ☐H2017	☐ Service threshold met		
Group Psychotherapy ☐ 90853	☐ Same day services		
*TBS Day Treatment (Hourly) ☐ H2012	☐ Same day services		
*TBS Day Treatment (Per Diem) ☐H2020	☐ Day 1 Authorization Required ☐ Service threshold met ☐ Same day services		
OhioRISE Only Services	**Service Code**	**Units/Visits Requested**	**Requested Start Date or Dates of Service**
**Behavioral Health Respite	☐S5150 ☐S5151		
**Intensive Home-Based Treatment	☐H2033 ☐H2015		
Primary Diagnosis (ICD 10):			

***For services marked with *, providers are required to complete Section IV: Medical Necessity Criteria**
****Services marked with # may require additional assessment results to be provided (e.g. ANSA, CANS, [including CIP-IHBT version], Achenback)**

Section IV: Medical Necessity Criteria (For TBS, PSR, TBS Day Treatment, and CPST only)
Select the check box next to the service(s) you are requesting for the member. All corresponding clinical criteria for that service must be met for member to qualify for prior authorization.

☐ Therapeutic Behavioral Services (TBS)

☐Member demonstrates one or both of the following (select all that apply):
- (a) ☐ Onset or worsening of symptoms associated with mental health condition
- (b) ☐ Persistent mental health symptoms that impair functioning in daily life

☐Member would benefit from services that promote acquisition of coping skills or other evidence-based techniques to reduce or alleviate symptoms of mental illness.

☐ Treatment plan clearly describes measurable goals related to symptom management AND (select all that apply):
- a) ☐Describes how INDIVIDUAL TBS services will be used to reduce or alleviate mental health symptoms.
- b) ☐Describes how GROUP TBS services will be used to reduce or alleviate mental health symptoms.

☐ Psychosocial Rehabilitative Services (PSR)

☐Member experiences functional limitations in at least one of the following life domains (select all that apply):
- (a) ☐ Independent living (managing budget, housing stability, nutrition, self-care)
- (b) ☐ Social Skills
- (c) ☐ Community integration (participation in family, community, or workplace)

☐Member would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in major life domains.

☐Treatment plan clearly describes measurable goals related to functional limitations and how PSR services will be used to restore skills.

☐ Therapeutic Behavioral Services Day Treatment Hourly / Per Diem

☐Member demonstrates acute onset or worsening of symptoms associated with mental health condition that significantly disrupt daily functioning.
☐Member would benefit from services that promote acquisition of coping skills or other evidence-based techniques to reduce or alleviate symptoms of mental illness.
☐Member requires a highly structured environment to support skills acquisition and facilitation.
☐Treatment plan clearly describes measurable goals related to symptom management and how day treatment services will be used to stabilize functioning.
☐Treatment plan includes measurable discharge criteria and plan for transitioning member to a lower level of care.
☐Request includes an individualized sample schedule demonstrating the duration, frequency, and intensity of day treatment program.

☐ Community Psychiatric Supportive Treatment (CPST)

☐Member has mental health condition(s) requiring ongoing management by multiple providers AND would benefit from a coordinated plan of care that includes collaboration among care providers and natural supports.
☐Member is at risk of treatment non-adherence due to mental health condition(s)
☐Member would benefit from services that promote acquisition of coping skills or other evidence-based techniques to reduce or alleviate symptoms of mental illness.
☐ Member needs assistance with linkages to community supports and services.
☐ Clinical documentation clearly demonstrates member's difficulty following treatment plans without support.
☐ One or both of the following is true (select all that apply):

a) ☐Treatment plan clearly describes how INDIVIDUAL CPST services will be used to assist member in achieving goals in ISP.
b) ☐Treatment plan clearly describes how GROUP CPST services will be used to assist member in achieving goals in ISP.

Required Supporting Information

Describe any recent circumstances such as hospitalizations, life transitions, health-related social needs, multi-system involvement, and/or scores from clinical symptoms rating scales, etc. that support member's need for the requested service(s). Attach an additional document if more space is needed.

Signature of Staff Completing the Form	
Name (print):	
Signature/Credential:	**Date:**