OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

Revised 02-05-2007

APS Healthcare, Inc.
4545 Lincoln Boulevard Suite 103
Oklahoma City, OK. 73105
800-762-1560 (Main)/800-762-1639 (FAX)

FAX DATE: _____
TIME: _____

TYPE OF FAX: (Mark only ONE of the following by typing "X")

☐ **1. INITIAL REQUEST**

☐ **2. EXTENSION REQUEST**

☐ **3. MODIFICATION REQUEST** (Attention: Reviewer)

☐ **4. CORRECTION REQUEST** (Attention: Reviewer)

☐ **OTHER** _____

☐ **5. IMPORTANT NOTICE RESPONSE** (Attention: Reviewer)

☐ **6. PENDING ELIGIBILITY RESPONSE** (Attention: Reviewer)

☐ **7. PROVIDER CHANGE OF DEMOGRAPHIC INFORMATION** (Attention: Clerical Staff)

TO: APS – Medicaid Outpatient Preauthorization Unit **ATTENTION**: _____
FAX NUMBER: (800) 762-1639 (Reviewer)

FROM: FACILITY/AGENCY: _____

CONTACT NAME: _____

PROVIDER ID #: _____ **CASE MGMT ID #:** _____

Check One: ☐ **Mental Health Request** ☐ **Substance Abuse /Integrated Request**

FACILITY ADDRESS: _____
Street **City** **State** **Zip**
FAX NUMBER: _____**PHONE NUMBER:** _____

RE: CLIENT NAME: _____
First, MI, Last, Designation (Sr., Jr., III, etc.)
RECIPIENT ID #: _____ **PA #:** _____
(If Applicable)

NUMBER OF PAGES INCLUDING THIS PAGE: ___

COMMENTS: (NO clinical information) _____

CONFIDENTIALITY

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Client Name:_____
First, MI, Last, Designation (Sr., Jr., III, etc.)

Social Security # _____ **Legal Guardian Name:**

Relationship to Client: **Date of Birth:** **Age: ___ Sex: _____**
MM/DD/YY

Current Residence: (Mark ALL that apply by entering "x")

☐ **Systems of Care** ☐ **Individual Home** ☐ **Residential Care Facility** ☐ **Group Home (Level___)**

☐ **Nursing Home** ☐ **Shelter** ☐ **ICF/MR (Admit Date:_____)**

☐ **DHS/OJA/IH Custody (Worker:_____ Phone#_____)**

☐ **Foster Care (Placement Date:_____)** ☐ **TFC**

☑ **Multiple placements in past 2 years (#_____)**

LEVEL: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **Exceptional Case** ☐ **0-36 months** ☐ **ICF/MR** ☐ **RBMS**

ADMIT DATE TO CURRENT FACILITY:

TREATMENT HISTORY: (Admit / Discharge dates, facility, IP or OP, reason for treatment)

_____

ICD-9-CM DIAGNOSES and DSM Axes: (Complete ICD-9-CM diagnoses and DSM axes):

Axis I: ICD-9-CM (code and title): _____ _____

_____ _____

_____ _____

Axis II: _____

_____

Axis III: _____

Axis IV:
Problems related to: ☐ Primary support group ☐ Social environment ☐ Education ☐ Housing

☐ Economic ☐ Occupation ☐ Access to health care services ☐ Interaction with legal system/crime

Other ☐ ___

Axis V: Current GAF:_____ Highest Level in the Past Year:_____

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HISTORICAL INFORMATION (relevant to current diagnosis and treatment): _____

CLIENT ASSESSMENT RECORD **Past** **Current**

1. FEELINGS/MOOD/AFFECT **SCORE** _____ _____

Problem areas: ☐ Mood lability ☐ Coping skills ☐ Suicidal/homicidal ideation/plan ☐ Depression ☐ Anger

☐ Anxiety ☐ Euphoria ☐ Change in appetite/sleep patterns.

Evidenced by (specific examples, frequency, duration and intensity, and impact on daily functioning) _____

2. THINKING/MENTAL PROCESS **SCORE** _____ _____

Oriented x ___ MMSE score (if administered) _____ IQ Score (if MR diagnosis) _____

Problem areas: ☐ Memory ☐ Cognitive process ☐ Concentration ☐ Judgment

☐ Obsessions ☐ Delusions/hallucinations ☐ Belief system ☐ Learning disabilities

☐ Impulse Control.

Evidenced by (specific examples, symptom frequency, duration and intensity, impact on daily functioning): _____

3. SUBSTANCE USE: **SCORE** _____ _____

Drug of Choice	Amount Used	Frequency of Use	First Used	Last used

Functional impact of current use, give examples of level of dependency_____

4. MEDICAL/PHYSICAL **SCORE** _____ _____

Current Medical/physical conditions_____

Impact/limitations on day-to-day function _____

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MEDICATIONS

Name of Rx Dosage/Frequency Reason for Rx

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. FAMILY **SCORE ___ ___**

Currently resides with: ☐ biological family ☐ adoptive family ☐ foster family

☐ Alone ☐ Other _____

Problem areas: ☐ Parenting ☐ Conflict ☐ Abuse/violence ☐ Communication

☐ Marital ☐ Sibling ☐ Parent/child

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)

6. INTERPERSONAL **SCORE ___ ___**

Problem areas:

☐ Peers/friends ☐ Social interaction ☐ Withdrawal ☐ Make/keep friends ☐ Conflict

Evidenced by (specific examples, frequency, duration, intensity, impact on daily functioning)

7. ROLE PERFORMANCE **SCORE ___ ___**

Functional role: ☐ Employment/Volunteer ☐ School/daycare ☐ Home management ☐ Other _____

Effectiveness of functioning in identified role: _____

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)

_____

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8. SOCIO-LEGAL **SCORE** _____ _____

Problem areas: ☐ Ability to follow rules/laws ☐ Authority issues ☐ Legal issues ☐ Aggression
☐ Probation/parole ☐ Abides by personal ethical/moral value system ☐ Antisocial behaviors

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)

_____

9. SELF-CARE/BASIC NEEDS **SCORE** _____ _____

Problem areas: ☐ Hygiene ☐ Food ☐ Clothing ☐ Shelter ☐ Medical/dental needs ☐ Transportation

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning) _____

10. COMMUNICATION (required for ICF/MR level of care) ☐ ESL ☐ Hearing impaired ☐ Non-verbal
☐ Uses interpreter ☐ Signs ☐ Uses mechanical device ☐ Speech impaired ☐ Fluency

_____

INTERPRETIVE SUMMARY/ADDITIONAL INFORMATION:

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MENTAL HEALTH SERVICE PLAN

☐ **Low Complexity** ☐ **Moderate Complexity**

PROBLEM 1: _____
GOAL 1: _____

CURRENT OBJECTIVES: (Must be behaviorally measurable)

1a: _____

1b: _____

1c: _____

1d: _____

	TYPE OF SERVICE	DATE INITIATED	TARGET DATE
1a: _____			
1b: _____			
1c: _____			
1d: _____			

PROGRESS ON CURRENT/PREVIOUS GOAL SINCE LAST AUTHORIZATION:
(Extension Requests Only)

_____

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

PROBLEM 2: _____
GOAL 2: _____

CURRENT OBJECTIVES: (Must be behaviorally measurable)

2a: _____

2b: _____

2c: _____

2d: _____

TYPE OF SERVICE	DATE INITIATED	TARGET DATE
2a: _____		
2b: _____		
2c: _____		
2d: _____		

PROGRESS ON CURRENT/PREVIOUS GOAL SINCE LAST AUTHORIZATION:
(Extension Requests Only)

_____

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

PROBLEM 3: _____
GOAL 3: _____

CURRENT OBJECTIVES: (Must be behaviorally measurable)

3a: _____

3b: _____

3c: _____

3d: _____

	TYPE OF SERVICE	DATE INITIATED	TARGET DATE
3a: _____			
3b: _____			
3c: _____			
3d: _____			

PROGRESS ON CURRENT/PREVIOUS GOAL SINCE LAST AUTHORIZATION:
(Extension Requests Only)

_____

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

PROBLEM 4: _____
GOAL 4: _____

CURRENT OBJECTIVES: (Must be behaviorally measurable)

4a: _____

4b: _____

4c: _____

4d: _____

TYPE OF SERVICE	DATE INITIATED	TARGET DATE
4a: _____		
4b: _____		
4c: _____		
4d: _____		

PROGRESS ON CURRENT/PREVIOUS GOAL SINCE LAST AUTHORIZATION:
(Extension Requests Only)

_____

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SIGNATURE PAGE

I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I have the following comments/response:

I/We ☐ Agree ☐ Disagree with this service plan.

Mark One Response

Client Signature, 24 or older Date Parent/Guardian Signature Date

Witness: _____ Relationship to client: _____

If unable to sign, document reason: _____

TREATMENT TEAM:

_____

Responsible MHP Signature, Degree/License ____Date _____ Physician, Credentials ____Date

☐ Physician signature not required

Type of Service	Frequency of Service per week	Staff/Credentials (Print)	Signature	Date
Ind Psy _____				
Int Psy _____				
Grp Psy _____				
Fam Psy _____				
P/S Reh-G _____				
P/S Reh-I _____				
A/D Skill/Dev -G _____				
A/D Skill/Dev-I _____				
Psy Test _____				
Med T/ S _____				
C/M _____				
_____				
_____				
_____				

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Recipient ID #:____ Provider #:____ Location: __ Case Mgmt: __

CHILD RVU PAGE (under 21 years old)

CHILD Psychotherapy:

Child Individual Psychotherapy: ____ **# of 20-30 min sessions per month =** ____ **RVU's per month (1 unit = 0.9676 RVU's)**

____ **# of 45-50 min sessions per month =** ____ **RVU's per month (1 unit = 1.4591 RVU's)**

____ **# of 75-80 min sessions per month =** ____ **RVU's per month (1 unit = 2.1786 RVU's)**

Child Interactive Psychotherapy: ____ **# of 20-30 min sessions per month =** ____ **RVU's per month (1 unit = 1.0448 RVU's)**

____ **# of 45-50 min sessions per month =** ____ **RVU's per month (1 unit = 1.5694 RVU's)**

____ **# of 75-80 min sessions per month =** ____ **RVU's per month (1 unit = 2.2787 RVU's)**

Child Family Psychotherapy w/ Client:

____ **# of 60 min sessions per month =** ____ **RVU's per month (60 min = 1.7284 RVU's)**

Child Family Psychotherapy w/o Client:

____ **# of 60 min sessions per month =** ____ **RVU's per month (60 min = 1.5774 RVU's)**

Child Group Psychotherapy: ____ **# of 60 min sessions per month=** ____ **RVU's per month (60 min = 0.6783 RVU's)**

Total CHILD Psychotherapy RVU's per month= ____

CHILD Psychosocial Rehabilitation or Alcohol and/or Substance Abuse Treatment Services, Skills Development and Case Management

For Rehab and Case Management: Each 60 min. session equals 4 units and RVU's have been adjusted accordingly.

Child Group Rehab: ___ **# of 60 min sessions per month =** ____ **RVU's per month**
Or Skills Development **(60 min = 0.4244 RVU's)**

Child Individual Rehab: ___ **# of 60 min sessions per month =** ____ **RVU's per month**
Or Skills Development **(60 min = 1.1232 RVU's)**

Child Case Management: Direct ___ **# of 60 min sessions per month =** ____ **RVU's per month (60 min = 1.3304 RVU's)**

Child Case Management: Indirect ___ **# of 60 min sessions per month =** ____ **RVU's per month (60 min = 1.0648 RVU's)**

Total CHILD Rehabilitation/Skills Development/Case Management per month = ____

Combined Total CHILD RVU's = ____

Requested Authorization Dates: Start Date: ____ ☐ **3 month** ☐ **6 month** ☐ **Extended Level of Care**

Additional / Optional CHILD Services:

CHILD Medication Training and Support: ____ **# of sessions per month**

CHILD Psychological Testing: ____ **# of hours**

CHILD Behavioral Health Aide: ____ **# of hours**

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

Recipient ID #:_____ Provider #:_____ Location: __ Case Mgmt: __

ADULT RVU PAGE (21 years old and older)

ADULT Psychotherapy:

Adult Individual Psychotherapy: ____ **# of 20-30 min sessions per month =** _____ **RVU's per month (1 unit = 1.0085 RVU's)**

____ **# of 45-50 min sessions per month =** _____ **RVU's per month (1 unit = 1.9164 RVU's)**

____ **# of 75-80 min sessions per month =** _____ **RVU's per month (1 unit = 3.1264 RVU's)**

Adult Interactive Psychotherapy: ____ **# of 20-30 min sessions per month =** _____ **RVU's per month (1 unit = 1.0589 RVU's)**

____ **# of 45-50 min sessions per month =** _____ **RVU's per month (1 unit = 2.0121 RVU's)**

____ **# of 75-80 min sessions per month =** _____ **RVU's per month (1 unit = 3.2828 RVU's)**

Adult Family Psychotherapy: ____ **# of 60 min sessions per month =** _____ **RVU's per month (60 min = 2.53 RVU's)**

Adult Group Psychotherapy: ____ **# of 60 min sessions per month=** _____ **RVU's per month (60 min = 1.21 RVU's)**

Total ADULT Psychotherapy RVU's per month= _____

ADULT Psychosocial Rehabilitation or Alcohol and/or Substance Abuse Treatment Services, Skills Development and Case Management

For Rehab and Case Management: Each 60 min. session equals 4 units and RVU's have been adjusted accordingly.

Adult Group Rehab: Or Skills Development ___ **# of 60 min sessions per month =** _____ **RVU's per month (60 min = 0.50 RVU's)**

Adult Individual Rehab: Or Skills Development ___ **# of 60 min sessions per month =** _____ **RVU's per month (60 min = 1.80 RVU's)**

Adult Case Management: Direct ___ **# of 60 min sessions per month =** _____ **RVU's per month (60 min = 1.94 RVU's)**

Total ADULT Rehabilitation/Skills Development/Case Management per month = _____

Combined Total ADULT RVU's = _____

Requested Authorization Dates: Start Date: _____ ☐ **3 month** ☐ **6 month Authorization period (check one)**

☐ **Extended Level of Care**

Additional / Optional ADULT Services:

ADULT Medication Training and Support: _____ **# of sessions per month**

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ADDENDUM

Completion of this page of the request packet is optional for the provider and is not required for the preauthorization process at APS. The items listed on this page, however, may be required documentation for SURS reviews, CARF certification and/or JCAHO certification. Please do not submit this form to APS as part of the request packet unless instructed as a specific request by an APS review coordinator.

COMMUNITY INTEGRATION:

_____

CAREGIVER RESOURCES (for clients under the age of 22):

_____

CLIENT'S STRENGTHS/ABILITIES (in client's own words):

_____

CLIENT'S LIABILITIES/NEEDS (in client's own words):

_____

THEORETICAL APPROACH BEING UTILIZED WITH INDIVIDUAL PSYCHOTHERAPY:

_____

COLLABORATION WITH SCHOOL SYSTEM (school age children only):

_____

REFERRALS TO OTHER COMMUNITY SERVICES:

_____

DISCHARGE PLAN:

a. CRITERIA (client-specific behaviors):

_____

b. ESTIMATED DATE OF DISCHARGE (M/Y): _____

c. AFTERCARE PLAN:

_____