

Member's Full Name:

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# SERVICE AUTHORIZATION FORM

## THERAPEUTIC DAY TREATMENT (TDT) H0035 INITIAL Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian:		Clinical Contact Name & Credentials*:	
Parent/Guardian Contact Information:		Clinical Contact Phone:	
		* This is the individual to whom the MCO can reach out to answer additional clinical questions.	

**Procedure Code:**  H0035 – HA (school day)     H0035 – HA, UG (after-school)     H0035 – HA, U7 (summer)

**Provide the name of the school (and/or other setting) where these services are being provided:**

**Request for Approval of Services:** **Retro Review Request?**  Yes  No  
 From \_\_\_\_\_ (date), To \_\_\_\_\_ (date), for a total of \_\_\_\_\_ units of service.  
 Plan to provide \_\_\_\_\_ hours of service per week.

**Is this a new service for the member?**  Yes  No (If no, then complete an authorization for continuing care.)

<b>Primary ICD-10 Diagnosis</b>	
<b>Secondary Diagnosis</b>	

Name of Medication	Dosage	Frequency

If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.

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**SECTION I: THERAPEUTIC DAY TREATMENT ELIGIBILITY CRITERIA**

Individuals shall demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness resulting in significant functional impairments in major life activities. Individual must meet **TWO** of the following on a continuing or intermittent basis; check applicable criteria:

Has difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out of home placement because of conflicts with family or community (Note: Please refer to DMAS provider manual for risk of hospitalization and out of home placement definitions/criteria).  Yes  No

*\* If a child is at risk of hospitalization or an out of home placement, state the specific reason and what the out-of-home placement may be.*

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):

- Does the individual have an IEP?  Yes  No
- # of days unexcused absences in the school year:
- # of days of in-school suspensions in the past 6 months:
- # of days out of school suspensions in the past 6 months:
- # of classes taking and how many are passing grades:

Exhibits such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.  Yes  No

Describe current and past services/interventions which provides substantiation for CHECKED response as stated above:

Provider	Currently in Service?	Dates of Services/ Interventions	Outcomes/Current Progress
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.  Yes  No

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):

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<b>Individual must meet <u>ONE</u> of the following; check applicable criteria:</b>	
<b>The individual must require year-round treatment to sustain behavior or emotional gains</b>  Describe pertinent information which provides substantiation for CHECKED response (ex. What services have been tried and with what result, Describe severity and intensity of behaviors):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual's behavior and emotional problems are so severe that they cannot be handled in a self-contained or resource emotionally disturbed (ED) classroom without:</b> a. TDT programming during the school day or b. TDT programming to supplement the school day or school year  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual would otherwise be placed on homebound instruction because of severe emotional/behavioral problems that interfere with learning.</b>  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual must have deficits in social skills, peer relations or dealing with authority, are hyperactive, have poor impulse control, are extremely depressed or marginally connected with reality.</b>  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual is placed or pending placement in a preschool enrichment and or early intervention program but the individuals emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted to these programs without TDT services.</b>  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**SECTION II: CARE COORDINATION**

**Primary Care Physician:**

**Other medical/behavioral health concerns (including substance abuse issues, developmental/cognitive impairments) that could impact services?**  Yes  No (If yes, explain below.)

**Please indicate other current medical/behavioral services and additional community supports and interventions being received:**

Name of service/treatment	Provider/Contact Information	Frequency

**Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:**

**SECTION III: TRAUMA-INFORMED CARE**

**Trauma-Informed Care** (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)

**Is there evidence to suggest this member has experienced trauma?**  Yes  No

**What is your plan to assess/refer and address the current and potential effects of that trauma?**

**SECTION IV: INDIVIDUAL TREATMENT GOALS**

**Treatment Goals/Progress:**

- Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions in the treatment plan.
- Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential.
- Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress.

**Resources and Strengths:** Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.

**Please describe any barriers to treatment:**

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<p><b>Please describe how coordination of TDT services will occur with school personnel and identified family member(s) involved in individual's care on a daily/weekly basis (i.e. treatment meetings, progress reports, correspondence with family, etc.):</b></p>
<p><b>Goal/Objective</b> (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):</p>
<p><b>How many days per week will be spent addressing this goal on average?</b></p>
<p><b>What specific counseling (LMHP Type) and/or behavioral interventions will be provided to address this goal?</b></p>
<p><b>How will you measure progress on the counseling or interventions provided?</b></p>
<p><b>Goal/Objective</b> (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):</p>
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**Goal/Objective** (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):

**How many days per week will be spent addressing this goal on average?**

**What specific counseling (LMHP Type) and/or behavioral interventions will be provided to address this goal?**

**How will you measure progress on the counseling or interventions provided?**

**SECTION V: DISCHARGE PLANNING**

**DISCHARGE PLAN** (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)

Step Down Service/Supports	Identified Provider/Supports	Objectives to assist in transition

Recommended level of care at discharge:

*The Therapeutic Day Treatment Service Specific Provider Intake has been completed by the LMHP Type and the treatment history information reviewed. It is determined that the individual meets the TDT criteria.*

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**Name of LMHP and Credentials** **Date**

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**NOTES SECTION**

**If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.**

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**PLEASE SEND FORM TO THE DESIGNATED HEALTH CARE PLAN USING THE CONTACT INFORMATION BELOW FOLLOWING THE TIME FRAME REQUIREMENTS ALSO BELOW**

All MCOs rely on Contract Standards; 3 business days or up to 5 business days if additional information is required.

CONTACT INFORMATION			
Commonwealth Coordinated Care (CCC) Plus	Phone Number	Fax Number	Web Portal
<b>Aetna Better Health of Virginia</b>	855-652-8249	855-661-1828	<a href="https://www.aetnabetterhealth.com/virginia/providers/portal">https://www.aetnabetterhealth.com/virginia/providers/portal</a>
<b>Anthem HealthKeepers Plus</b>	800-901-0020	866-877-5229	<a href="https://medproviders.anthem.com/va/pages/precert.aspx">https://medproviders.anthem.com/va/pages/precert.aspx</a>
<b>Magellan Complete Care of Virginia</b>	800-424-4524	866-210-1523	Pending/TBA 2018
<b>Optima Health Community Care</b>	888-946-1168	844-348-3719 (BH Inpatient) 844-895-3231 (BH Outpatient)	<a href="http://www.optimahealth.com">www.optimahealth.com</a>
<b>United Healthcare</b>	877-843-4366	855-368-1542	<a href="http://www.providerexpress.com">www.providerexpress.com</a>
<b>Virginia Premier Health Plan</b>	844-513-4951	888-237-3997	Pending/TBA 4/1/2018

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INITIAL REQUEST	Registration vs. Authorization CONTINUED STAY REQUEST
Mental Health Case Management	H0023	R	R
Mental Health Peer Support Services – Individual	H0025	R	A
Mental Health Peer Support Services – Group	H0024	R	A
Crisis Intervention	H0036	R	A
Crisis Stabilization	H2019	R	A
Intensive Community Treatment	H0039	A	R
Intensive In-Home	H2012	A	A
Therapeutic Day Treatment (TDT) for Children *TDT School Day	H0035 *HA	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Afterschool	H0035 *HA *UG	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Summer	H0035 *HA *U7	A	A
Day Treatment/ Partial Hospitalization *Adults	H0035 *HB	A	A
Mental Health Skill-building Services (MHSS)	H0046	A	A
Psychosocial Rehab	H2017	A	A
EPSDT Behavioral Therapy (ABA)	H2033	A	A

Timeframe Requirements for Submission (Concurrent)	CMHRS Services (excluding CI/CS)	CI/CS
Aetna	7 business days	48 hrs.
Anthem	14 business days	48 hrs.
MCC	7 business days	48 hrs.
Optima	7 business days	48 hrs.
United Healthcare	14 business days	48 hrs.
Virginia Premier	14 business days	48 hrs.