DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	September 1, 2015	Initial version of Uniform Managed Care Manual Chapter 15.4, "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Instructions" Chapter 15.4 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.

[1] Status is represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions are numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

Use of Texas Standard Prior Authorization Request Form for Health Care Services for Mental Health Targeted Case Management and Mental Health Rehabilitative Services

Applicability of Chapter 15.4

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, STAR Health, and STAR Kids Programs. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration), STAR Health, and STAR Kids Programs. The term "MCO" may include health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all programs, except where noted.

Purpose and Background

Effective September 1, 2015, MCOs are required to accept the Texas Standard Prior Authorization Request Form for Health Care Services developed by the Texas Department of Insurance. A copy of the form can be found here: http://www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf . The instructions in this chapter are to be used if submitting the form for mental health rehabilitative services and mental health targeted case management. Providers may continue to submit, and MCOs are required to accept the Service Request Authorization (SRF) form (UMCM Chapter 15.2) until January 1, 2016.

Section I - Submission

***Issuer Name**:* Include the Managed Care Organization (MCO) name

Phone: Insert MCO phone number

Fax: Insert MCO fax number

Date: Insert date authorization request form is completed by provider

Section II - General Information

Review Type: Leave both check boxes blank

Request Type: Check "Initial Request" if the authorization form represents an initial assessment; check "Extension / Renewal / Amendment" if the authorization form represents a member reassessment

Clinical Reason for Urgency: Leave this box blank

Previous Auth. #: Leave this box blank

Section III - Patient Information

Name: Include the member name

Subscriber Name (if different): Include "N/A" or leave blank

Phone: Include member phone number

Member or Medicaid ID #: Include member Medicaid identification number

DOB: Include the member date of birth

Group #: Include "N/A" or leave blank

Sex: Check the applicable box representing the sex of the member

Section IV - Provider Information

Requesting Provider or Facility

Name: Name of provider agency

NPI: National Provider Identification Number of provider agency

Specialty: Include "Behavioral Health"

Phone: Provider agency phone number

Fax: Provider agency fax number

Contact Name: Name of person who can answer MCO questions related to authorization request

Phone: Phone number of person who can answer MCO questions related to authorization request

Requesting Provider's Signature and Date (if required): Include "N/A" or leave blank

Service Provider or Facility

Leave this section blank if provider is the same as the requesting provider. If different than the requesting provider, complete as specified below.

Name: Populate with name of provider agency.

NPI: National Provider Identification Number of provider agency

Specialty: Include "Behavioral Health"

Phone: Provider agency phone number

Fax: Provider agency fax number

Primary Care Provider Name: Include "N/A" or leave blank

Phone: Include "N/A" or leave blank

Fax: Include "N/A" or leave blank

Section V - Services Requested

Planned Service or Procedure: Include the level of care being requested by the provider. This may be the level of care generated by the Clinical Management for Behavioral Health Services (CMBHS) system, or it may be a clinician requested deviation.

Code: Include "N/A" or leave blank

Start Date: Include the service begin date generated by CMBHS

End Date: Include the service end date generated by CMBHS

Diagnosis Description: Include the member primary diagnosis. If using ICD code, note ICD version in heading

Code: Include the DSM or CPT Code applicable to the primary diagnosis

Check Boxes: *Inpatient, Outpatient, Provider Office, Observation, Home, Day Surgery, Other*: Check "other" and include "SB58"

Check Boxes: *Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehab, Mental Health / Substance Abuse:* Check "Mental Health / Substance Abuse"

Check Boxes: *Home Health, Number of Visits, etc:* Leave all fields in this row blank.

Check Boxes: DME, Number of Visits, etc: *Leave all fields in this row blank.*

Section VI - Clinical Documentation

1. Include the completion date of the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA).
2. If the level of care requested in Section V differs from the level of care generated from the CMBHS system, the provider should include the term "Deviation" followed by a justification for the deviation.

3. If required by the MCO, Provider must include a copy of the CANS or ANSA assessment with any deviation request.
4. If the request type is a reassessment, specify the result of the reassessment from the list below:
   - Reduction in level of care
   - Increase in level of care
   - Continuation of services at same level of care
   - Discontinuation of services / no medical necessity