

Client Name: _____ LME Record#: _____ Date Requested: _____

*If the patient's symptoms indicate they are in a crisis situation or in need of detox,
please contact the LME for further treatment options.*

CLINICAL APPROPRIATENESS

1. Since last UR, changes in situation, environment, behaviors, symptoms, services, tx compliance:

Behaviors:

Interventions:

***Severity is with 5 being most severe. ** Goal is with 10 being met.**

a. _____

a. _____

1. Freq. _____

1. Freq. _____

2. Severity (1-5)* _____

2. Duration _____

3. Other _____

3. By whom _____

Circle progress toward goal.** 0 1 2 3 4 5 6 7 8 9 10

b. _____

b. _____

1. Freq. _____

1. Freq. _____

2. Severity (1-5)* _____

2. Duration _____

3. Other _____

3. By whom _____

Circle progress toward goal.** 0 1 2 3 4 5 6 7 8 9 10

c. _____

c. _____

1. Freq. _____

1. Freq. _____

2. Severity (1-5)* _____

2. Duration _____

3. Other _____

3. By whom _____

Circle progress toward goal.** 0 1 2 3 4 5 6 7 8 9 10

2. Client hospitalized within past year? Y N Where? Adm/Discharge Date? Why? _____

3. Emergency intervention types/dates since last review: _____

4. Was arrested/charged? Y N Reason? _____

5. Med changes? Y N Client Med compliant? Y N _____

6. Report current involvement of natural supports (family, school, church, DSS, DJJ, etc.):

7. How and under what circumstances are services being stepped down during this UR period? Explain step-down and/or discharge criteria/plans: _____

Signature (Provider of Services)

Date

Please use additional page for explanations if needed.

Revised 04/06/10

***Please Mail or Fax this completed document to the above-mentioned address or fax number.**

INSTRUCTION SHEET TREATMENT REQUEST FORM

Reminder: Substance abuse requires a release.

Pre-Certification: New client or new service.

Concurrent: Client currently receiving the service requested.

Urgent: Based on medical necessity, the service requested needs to be processed within 48 hours.

Routine: Non urgent request processed within state standards.

Request Date: The date that the practitioner fills out the form.

Patient Information

- **Patient Name:** Client's legal first, last name, and middle initial if known. Please do not use nicknames.
- **Client's date of Birth:** Client's month, day, and year of birth.
- **Insurance (circle one):** Client's insurance information
- **LME Client Record #:** Client's LME medical record number.
- **LME Authorization number:** Authorization number from the current authorization. (This will be on your prior authorization.)

Practitioner Information

- **Practitioner Name/Credentials/ID#:** The name, credentials and therapist number of practitioner
- **Provider Agency:** Name of group/agency providing service(s).
- **Location Address:** Practitioner mailing address.
- **Phone number:** Practitioner phone number - please include area code and extension.
- **First Date seen for this episode:** A new episode starts with the initiation of treatment when a client hasn't been seen for six months or more.

DSM-IV Diagnosis:

- **Axis I:** DSM diagnosis code and name - Clinical Disorders, other conditions that may be a focus of clinical attention.
- **Axis II:** DSM diagnosis code and name - Personality disorder, Mental Retardation.
- **Axis III:** General Medical Conditions.

- **Axis IV:** Psychosocial and environmental problems.
- **Axis V:** Global Assessment of Functioning (GAF) score
 - **AT First Session:** Score when client was first seen
 - **Highest in Past Year:** Highest GAF score in the past year
 - **Current:** Clients current score at the time of the assessment
- **DD-NC-SNAP:** SNAP Score for Developmental Disability clients.
- **Date Scored:** Month/day/year SNAP scored.
- **Target Population:** State identified target population
- **Target Population Exp. Date:** Date the target population expires.

<u>Current Medication</u>

- **Medication:** Name of medication. If no medication, please put “none”
- **Dosage:** How much is client to take
- **Frequency:** How often is client to take the medicine
- **Route:** How is client to take medication (oral injections, topical, etc...)

<u>Authorization Request</u>

- **How many times have you seen the patient in the current authorization period?** Number of times you have seen the client for this episode of care.
- **Service Code:** Ask by CPT, HCPCS (H-code), or State Code.
- **Dates requested:** Span of time you are requesting – please use start and end date. e.g.: 3/20/06 – 6/20/06.
- **Quantity:** How much of what you are requesting. e.g.: 30 -The units, etc. will go in the next slot labeled units. The two together will look like “30” units.
- **Units:** How the visits are quantified. e.g.: events, units, days, hours.
- **Agency, Address, & Staff Name:** Agency, address, and staff providing service(s). Address is needed if provider has multiple locations.

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Client Name: Client name

Record #: Client record number

Date Requested: The date that the practitioner fills out the form

If the patient’s symptoms indicate they are in a crisis situation or in need of detox, please contact the LME for further treatment options.

Client appropriateness: (Please be as detailed as possible)

1. Since last UR, changes in situation, environment, behaviors, symptoms, services, tx. compliance:

Make sure that the identified behaviors and interventions correspond with the Treatment Plan.

Behaviors: Behaviors should be specific and to the point. See last page of instructions for examples.

Frequency: List how often the behavior is happening. e.g.: once a day, once a month, and twice a week.

Severity (1-5): Circle the appropriate number with 5 being most severe.

Other: Is there anything else we may need to know about the behavior? e.g.: Where is it happening?

Interventions: List interventions used to address the behaviors.

Frequency: State how often the intervention is being used.

Duration: State how long the intervention is being used.

By Whom: List who did the intervention. e.g.: Community Support worker, Therapist, etc.

Circle progress toward Treatment goal: Circle the appropriate number - 10 being goal met.

2. Client hospitalized within the past year? Circle “Y” for Yes or “N” for no.

Where: State in which hospital the client was treated.

Admission and Discharge Date: List dates of hospitalization. e.g.: 2/2/06 – 2/10/06.

Why: State why the client was hospitalized. e.g.: suicidal, homicidal, etc.

3. Emergency intervention types/dates since last review: List types of emergency intervention such as Mobile Crisis, walk into Crisis Services, or went to the Emergency room. List the dates of Interventions.

4. Was arrested/charged? Circle “Y” for yes and “N” for no.

Reason: State why the client was arrested or charged.

5. Med changes? Circle “Y” for yes and “N” for no.

Client Med. Compliant? Circle “Y” for yes and “N” for no.

6. Report current involvement of natural supports (family, school, church, DSS, DJJ, etc.) List any natural supports and what their involvement is in the treatment of the client.

7. How and under what circumstances are services being stepped down during this UR period?

Explain step-down and/or discharge criteria/plans: State the step-down and/or discharge plan.

Signature (Provider of Services): Sign the Treatment Request form.

Date: Date you are preparing form. Please note that all requests are date-stamped when received and that is the date that will be used when determining authorization timelines.

EXAMPLES OF BEHAVIORS AND INTERVENTIONS:

Behaviors:

Interventions:

**Severity is with 5 being most severe. ** Goal is with 10 being met.*

- | | |
|---|---|
| <p>a. <u>Isolation</u>
 1. Freq. <u>Daily for 2 weeks</u>
 2. Severity (1-5)* <u>3</u>
 3. Other <u>Stays in bed most of day</u>
 Circle progress toward goal.** 0 1 (2) 3 4 5 6 7 8 9 10</p> <p>b. <u>Crying</u>
 1. Freq. <u>Multiple times daily</u>
 2. Severity (1-5)* <u>5</u>
 3. Other <u>Grief response</u>
 Circle progress toward goal.** 0 1 (2) 3 4 5 6 7 8 9 10</p> <p>c. <u>Feelings of hopelessness</u>
 1. Freq. <u>Average 2 times daily</u>
 2. Severity (1-5)* <u>4</u>
 3. Other <u>Relationship problems</u>
 Circle progress toward goal.** 0 1 2 (3) 4 5 6 7 8 9 10</p> <p>d. <u>Suicidal Ideation</u>
 1. Freq. <u>1 time per week</u>
 2. Severity (1-5)* <u>5</u>
 3. Other <u>JUH discharge last week</u>
 Circle progress toward goal.** 0 (1) 2 3 4 5 6 7 8 9 10</p> <p>e. <u>Verbal threats</u>
 1. Freq. <u>Average 2 times daily</u>
 2. Severity (1-5)* <u>4</u>
 3. Other <u>toward brother/family</u>
 Circle progress toward goal.** 0 1 2 (3) 4 5 6 7 8 9 10</p> | <p>a. <u>Individual therapy once a week</u>
 1. Freq. <u>once a week</u>
 2. Duration <u>50 minutes once a week</u>
 3. By whom <u>Jane Doe, LPC</u></p> <p>b. <u>Group Therapy</u>
 1. Freq. <u>Two weeks</u>
 2. Duration <u>Weekly, 1:15 min.</u>
 3. By whom <u>Jane Dope, LPC</u></p> <p>c. <u>Group therapy</u>
 1. Freq. <u>Once every week</u>
 2. Duration <u>weekly</u>
 3. By whom <u>Jane Doe, LPC</u></p> <p>d. <u>24 hr access, meds increase, supportive counseling</u>
 1. Freq. <u>As needed</u>
 2. Duration <u>As long as needed</u>
 3. By whom <u>ACTT provider</u></p> <p>e. <u>Family counseling</u>
 1. Freq. <u>Once every week</u>
 2. Duration <u>1:15 minutes</u>
 3. By whom <u>John and Jane Doe</u></p> |
|---|---|

You may always use additional pages for explanations if needed.