**THERAPEUTIC BEHAVIORAL SERVICES (TBS)**

**PRIOR AUTHORIZATION REQUEST & REFERRAL FORM** Initial Request  Continuing Request (6 mos.)

(submitted by SMHP) (Submitted by TBS provider)

\* Indicates a required section for Initial Requests

**Youth Information\*:**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Name: | \*DOB: | | \*Medi-Cal or SSN: |
| \*Current Address: | | | |
| School: | | School District: | |
| \*Parent/Caregiver Name: | | \*Parent/Caregiver Phone: | |

**Referring Party/Therapist Information**\*: ***Please Note: Client must be receiving services from a Specialty Mental Health Provider (SMHP) billing Medi-Cal.***

|  |  |
| --- | --- |
| \*SMHP Name: | \*SMHP Credential: |
| \*SMHP Program Name: | \*Address: |
| \*Phone: | \*Fax: |

**Additional Referring Party Information:** (*If same as SMHP, please leave blank)*

|  |  |  |
| --- | --- | --- |
| Name: | Agency: | Relationship: |
| Address: | | |
| Phone: | Fax: | E-Mail: |

**CWS/Probation Involved:**  Yes  No CWS Contact Name:       Probation Contact Name:

|  |  |  |
| --- | --- | --- |
| Phone: | Fax: | E-Mail: |

**Other Party Involvement:**  *(i.e. CASA, Mentor, Attorney, Big Brother/Sister, etc.)*

|  |  |
| --- | --- |
| Name/Relationship: | Contact Phone: |
| Name/Relationship: | Contact Phone: |

**Specific requests with regard to TBS Coach’s language, culture, gender, etc.:**

**TBS Class Criteria / Eligibility (Completed by SMHP)\*** – *All questions below require completion.*

1. Is Youth a full-scope Medi-Cal beneficiary under age 21?  **Yes**  **No** **AND**
2. Is Youth receiving specialty mental health services from a Medi-Cal funded therapist/case manager?  **Yes**  **No**
3. Which of the following conditions have been met by the Youth? *(\*Check all that apply, must check a minimum of 1)* Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** has had at least one emergency psychiatric hospitalization within the past 24 months  
     Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs  
     Youth may need out of home placement, a higher level of residential or acute care  
     Youth is transitioning to a lower level of care and needs TBS to support the transition  
     Youth has previously received TBS while a member of the certified class  
     Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

**Medical Necessity Criteria, completed by the SMHP\*:**

1. **\*Diagnosis for focus of TBS**:
2. **\*Client demonstrates impairment as a result of the included diagnosis** (*at least one of the following applies*):  
     significant impairment in an important area of life functioning   
    *e.g., living situation, daily activities, or social support*

**OR**

a reasonable probability of significant deterioration in an important area of life functioning

**OR**

a reasonable probability a person under 21 years of age will not progress developmentally as individually appropriate

1. \***Client meets each of the intervention criteria listed below:**
2. The focus of the TBS intervention will address the condition/impairment
3. Expectation that TBS will:

Significantly diminish the impairment **OR**

Prevent significant deterioration in an important area of life functioning **OR**

Allow the child to progress developmentally as individually appropriate

1. The condition would not be responsive to physical health care-based treatment
2. **\*Date of most recent Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR), or**

**Progress Note that demonstrates the above criteria Click to enter a date.**

1. \*SMHP Clinician is requesting the following TBS services: ***(Must include amount, scope & duration)***

Up to 25 hours of TBS Intervention per week - **amount**

TBS **scope** inclusive of Assessment (SC48), Plan Development (SC46), Intervention (SC47) and Collateral (SC49)

Up to 6 months of TBS Intervention – **duration**

Other *(explain any changes to amount, scope or duration being requested. Please note each authorization cycle is 6 months- Re-authorization may be obtained for additional services)*:

**SMHP submitted form to Optum on***:* **Click to enter a date**.

*(Optum shall notify provider of determination within 5 business days of receipt)*

**FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION**

☐ **OPTUM Reviewed BHA, OAR or Progress Note**

☐ **TBS scope, amount and duration authorized as requested: START** **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **END** **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Additional TBS hours authorized per week** (beyond 25 hours per week): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TBS Request is Reduced/Modified as follows:** ☐**scope** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐**amount** \_\_\_\_\_\_\_\_\_\_☐**duration** \_\_\_\_\_\_\_\_\_

**TBS request is** ☐**denied** ☐**modified** ☐**reduced** ☐**terminated or** ☐**suspended**

NOABD was issued to the beneficiary and provider on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Optum unable to confirmSMHP. Authorization is contingent on TBS provider confirming active SMHP claiming Medi-Cal.

**Optum** **Clinician Signature/Date/Licensure**:

***Typically, within two business days of Optum clinician signature, authorization will be forwarded to TBS and referring provider*****^Date pre-authorization received by TBS Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (^*completed by New Alternatives)*