

## **Behavioral Health/Chemical Dependency (BH/CD) Section**

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### **PRIOR AUTHORIZATION PROCESS**

**All Behavioral Health/Chemical Dependency (BH/CD) treatment performed by a social worker, certified counselor, psychologist, or psychiatrist requires Prior Authorization.**

**Prior Authorization for BH/CD for an initial evaluation is obtained by the member contacting UW Health Behavioral Health. Authorization for continued services following the initial evaluation are obtained by the behavioral health provider in coordination with the member.**

#### **UW Behavioral Health**

UW Behavioral Health (UW BH)  
(608) 282-8960 or (800) 683-2300

#### **Inpatient Services**

If a patient is admitted to any facility, including Meriter Hospital, UW Behavioral Health needs to be contacted by phone during business hours or the next business day for authorization and utilization review.

#### **Members in Crisis Seeking Emergency Treatment**

For emergencies, please contact the member's therapist. If the member does not currently have a therapist or cannot reach the therapist, call the Meriter/Park emergency room or any Physicians Plus-affiliated emergency room. Emergency room personnel will refer the member to the mental health/chemical dependency professional on call. During working hours, contact UW Behavioral Health at (608) 282-8960 or (800) 683-2300.

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### **Authorization for Outpatient Behavioral Health Services**

All outpatient behavioral health services require the submission of a completed "Initial Outpatient Treatment Request" form. A sample of this form is provided in this section. All fields must be completed, including the Axis I through Axis V diagnosis. The completed form must be received as soon as possible, but no later than 30 calendar days of the initial visit. Completed forms should be sent to UW Behavioral Health. In urgent cases the form can be faxed to (608) 287-5993.

### **Transitional/Partial Hospitalization**

Prior to admission into any transitional program, the psychiatrist or attending clinician must contact UW Behavioral Health for authorization and utilization review. This can be done by telephone or an "Initial Outpatient Treatment Request" form may be faxed to (608) 287-5993

### **Outpatient Treatment Guidelines**

The following are instructions in the use of the forms. The Treatment Request Forms are structured in a manner that directs you, as a treatment provider, to think about what the focus of treatment will be and what outcome goal you and the patient intend to reach. For purposes of providing examples, parts of the forms involved are duplicated in the guidelines. A completed form is also enclosed as a sample.

The Initial Treatment Request must be submitted following completion of an initial evaluation that will consist of whatever number of visits authorized by UW Behavioral Health. You will be notified, usually by fax, by phone or mail as necessary regarding the number of initial visits approved. Please submit the precertification forms as soon as possible. If the precertification form is not received within two weeks of the assessment, as required by your contract, some services may be denied and the member may not be billed. Any treatment provided prior to Physicians Plus approval may be denied and the member may not be billed.

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Identify the diagnosis as based on the initial assessment using DSM-IV. If the diagnosis changes during treatment, reflect such on the Follow-up Treatment Request form. It is necessary to fill in all five Axes (“no diagnosis” may be used). When submitting bills be sure that your billing codes accurately reflect your diagnosis because this information is used for utilization tracking.

Each individual provider must submit a separate Treatment Request Form for the services s/he intends to perform. You may request only services that you will provide. Any other services to be provided by a provider other than you must be requested on a separate form.

### **Treatment Philosophy**

Our treatment philosophy focuses on **functional impairments**. The term “Functional Impairment” describes a worsening, lessening, weakening or reduction in ability to function and in turn, anticipates a likely potential for repair, improvement and strengthening. They are observable, objective manifestations that may necessitate and justify use of the mental health benefit. There should be a connection between the diagnosis and the functional impairments in the patient’s life. The presence of a diagnosis is necessary, but not sufficient to justify use of the mental health benefit. Functional impairment is necessary, but not sufficient to justify use of the mental health benefit. Rather, use of the mental health benefit for treatment is indicated if the patient’s functioning is impaired and the impairment is caused by a diagnosable disorder. That is a covered benefit per the patient’s policy.

### **Functional Impairment Categories**

Five general categories of Functional Impairments are listed on the treatment form, along with spaces to enter Severity and Duration codes.

- a. PERSONAL/INDIVIDUAL: Impairments in this area reflect **a current** impact on one’s mental status **generated by the disorder**. Symptoms which could lead to functional impairment would be compulsions, delusions, hallucinations, eating disorders, hyperactivity, obsessions, paranoia, phobias, self-mutilation, psychotic thoughts and

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behavior, anhedonia, difficulty sleeping, insomnia, weight loss/gain and suicidal ideation and behavior and anxiety symptoms.

- b. FAMILY/SIGNIFICANT OTHER: Impairments in this area refer to the problems **generated by the disorder** within the patient's **current** primary relationships such as family and marital or other close relationships. A person's ability to relate to others is impaired. (This impairment in itself may not be a justification for use of the covered mental health benefit). Examples of impairments within the family and significant other category are family disruption, sexual dysfunction, running away from home, marital/relationship dysfunction, abuse perpetrator and victim of abuse.
- c. SOCIAL INTERPERSONAL: These are impairments **generated by the disorder** that impede a person's **current** ability to function, interact, negotiate or manage in his/her social environment. Habitual lying, assaultiveness, oppositionalism, homicidal thoughts/behavior, social withdrawal, sexual deviance, aggression and manipulation of others.
- d. WORK/SCHOOL/OTHER: In this sphere the disorder impairs a person in their **current** work, school, or training or in other attempts at achievement. Examples of impairments would be school phobia, truancy, absenteeism, test phobias, educational performance deficits, learning disability, low frustration tolerance, hopelessness, decrease or inability to function in civic activities or other personal endeavors or interests.
- e. AODA ISSUES: While not an impairment as the definition implies, it does suggest significant potential for impairment in one's functioning. It is singled out because it is an important consideration in determining the course and outcome of treatment. Examples of information in this category would be legal charges, work restrictions due to

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AODA use, blackouts, what they are using and how often.

Only the areas of impairment appropriate to the patient need to be completed. The same symptom or impairment may be appropriate in one or more categories. You can identify a functional impairment that is not significant at this time and it will not be a treatment focus. However, it does identify or “red flags” potential issues.

### **Severity Codes**

SEVERITY CODES are required for each impairment identified. The code is an approximate assessment of the severity of the presenting illness. The severity of the impairment provides some indication of the appropriate level of treatment or intervention. A functional impairment code of:

- 0 = None The impairment is not present; intervention is not medically necessary.
- 1 = Mild The impairment is only mildly disruptive in the patient’s life, but may need to be monitored or reevaluated in the future. Intervention may be a referral to a self –help group, patient education group, primary physician, etc.
- 2 = Moderate The impairment moderately comprises a person’s functioning. The impairment allows continued functioning in all settings, but it may produce some discomfort for the person. Treatment that is brief and specifically focused may be required to improve the functional impairment to the “mild” or “none” level of severity.
- 3 = Severe The impairment severely compromises ability to function without professional mental health services. A person has a major difficulty functioning in vocational endeavors, school and in relationships. Without treatment, functional impairments will increase.

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- 4 = Incapacitating    The patient is incapable of normal activity and/or is potentially dangerous to self and/or others. Urgent and intense treatment is necessary.
- Recent suicide behavior, threat or current ideation.
  - Recent violent and destructive behavior or current ideation.
  - Recent endangering runaway behavior or current ideation.
  - Severely compromised health care skills.
  - Frequent bizarre thoughts or behavior.

- 5 = Life Threatening    There is an imminent danger to self or to others. Immediate evaluation/intervention is necessary. High intensity or emergency treatment is necessary.
- Active suicide threats or behavior
  - Active violent and destructive behavior
  - Active endangering runaway behavior or risk
  - Demonstratable absence of or severely compromised reality testing
  - Total inability to perform self-care skills

### **Duration Codes**

Refer to the length of time the impairment has existed or the time frame of the most recent occurrence of the impairment.

### **Treatment Plan**

This section allows for specific description of the nature of the functional impairments identified as a treatment focus. The clinical outcome is the measure of treatment progress. It is the goal that the patient, with your guidance, hopes to achieve as a result of the treatment interventions. The **Outcomes** describe how treatment will improve functioning. Individualized outcomes must be identified for each impairment. If treatment is not recommended beyond evaluation, please state the reasons.

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You do not need to complete each impairment section in the **treatment request** if the impairment was not identified previously. Only complete the impairments identified. In the **Outcome** section note the outcome goals for each impairment. There can be more than one outcome for each impairment. Again, these must be measurable, observable goals.

Under the Additional Pertinent Information section on page two, you may add any historical, situational, familial, or clinical information that is important.

The intervention should be identified in the appropriate section on page two. Note the number of sessions requested for your interventions. Please note page two is the same for either initial or follow-up requests.

### **Neuropsychological Testing**

Neuropsychological testing for medical or psychological purposes will no longer require prior authorization when the service is performed by a participating provider. This change applies to all claims received on or after March 17, 2009.

This includes revenue code 918 and CPT codes 96115 through 96120.

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### **Psychological Testing**

**All psychological testing must be prior authorized before testing is administered.** If you are a provider requesting psychological testing, an explanation must be provided of how the testing will affect treatment and assist in attaining the desired clinical outcome. Why is psychological testing necessary? Please call to discuss your request. If psychological testing does seem to be indicated, UW BH will authorize the appropriate provider to perform the testing. If the provider recommending testing has a particular psychologist provider in mind for the testing, please note and this will be taken into consideration. A prior authorization form will be necessary for the psychologist to perform that psychological testing.

### **Projected End Date**

A projected end date for the interventions is required. Non-M.D. providers may plan for 6 months or less. M.D. providers may plan for up to one year for each request.

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### **Ancillary Services**

In the Ancillary Services Not Requiring Precertification section, note the other support services, treatments and other interventions to which you are referring the patient (e.g., education groups, AA, NA, Al-Anon, etc). These are services that do not fall under our benefit, but have an impact on the potential clinical outcome. Also, this is helpful information for MHCMCS in the review process for determining precertification of treatment.

### **Patient Signature**

The patient or responsible adult should be involved in the development of the treatment request. Because of the extended nature of treatment we want to assure that the patient understands the plan and is committed to following it. The Follow-up Treatment Request form will be verified by the patient's signature on the bottom of the form. (If you are unable to obtain the signature, please note that you will or have informed member of this plan.

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### **Follow-up Treatment Request**

The Follow-up Treatment Request form is completed in the same manner as the Initial Precertification, but with some differences as noted below.

1. Note the last date the patient was seen by you, the number of visits used/number of visits authorized in the last request and the approximate frequency of those visits.
2. Under the Current Functional Impairments section, identify the impairments that are active presently. These may be previous impairments unresolved or impairments not previously identified. Again, specific examples of the patient's behavior that document the Axis I diagnosis are necessary.
3. Reasons for Lack of Resolution/Improvement: Please include any other information that would help the reviewers understand the need for continued therapy and/or why it appears, there has been little or no significant improvement (ex: crisis occurring, Axis II issues appearing).
4. Additional Pertinent Information: may include an assessment of progress made during the initial treatment request period.

# University of Wisconsin Behavioral Health Initial Outpatient Treatment Request

Date Faxed: \_\_\_\_\_

Page: \_\_\_\_\_ of \_\_\_\_\_

Member or Subscriber Number: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  PPIC  UNITY

Provider's Name: \_\_\_\_\_ Panel Provider?  Yes  No Date of Last Visit: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ City: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**DSM IV Diagnosis Codes:** (Rank Axis I diagnoses according to treatment focus. Use DSM IV Codes where applicable.)

AXIS I	AXIS II	AXIS III	AXIS IV (List stressors)	AXIS V (GAF) (Current/Past Year)
_____	_____	_____	_____	_____ / _____
_____	_____	_____	_____	_____ / _____
_____	_____	_____	_____	_____ / _____

Functional Impairments: Codes:	Severity	Duration	Treatment Focus (Check One)
	0 = None 1 = Mild 2 = Moderate	3 = Severe 4 = Incapacitating 5 = Life Threatening	0 = < 1 Wk 1 = 1-2 Wk 2 = 2-8 Wk
		3 = 2-6 Mo 4 = 6-24 Mo 5 = >2 Yr	
1. Personal/Individual:	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Family/Significant Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Social/Interpersonal	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Work/School/Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. AODA Issues	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Treatment Plan** (For the impairments which will be addressed in treatment, fill out the following.)

**Impairments:** (Describe the specific nature of the clinical problem.)

- Personal/Individual: \_\_\_\_\_
- Family/Significant Other: \_\_\_\_\_
- Social/Interpersonal: \_\_\_\_\_
- Work/School: \_\_\_\_\_
- AODA Issues: \_\_\_\_\_

**Outcome** (Describe the specific change anticipated in functioning.)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Additional Pertinent Information:

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Other Providers Involved ? \_\_\_\_\_

Medications: \_\_\_\_\_ Prescribing Provider: \_\_\_\_\_

Are there other family members receiving treatment by a Mental Health Provider? If so, who? \_\_\_\_\_

**Treatment Plan Request**

Patient Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

**Provider Requested Service**

List the number of visits and identify duration wanted for each intervention which will address the impairment being treated. It is assumed that the medication management will be done during psychotherapy sessions, if these are done by a psychiatrist.

Intervention	Number of Visits	Begin Date	End Date	
<b>Individual Rx:</b> _____	_____	_____	_____	<b>Other (Specify):</b> _____
<b>Conjoint Rx:</b> _____	_____	_____	_____	_____
<b>Family Rx:</b> _____	_____	_____	_____	<b>Ancillary services not requiring pre-certification:</b> _____
<b>Group Rx:</b> _____	_____	_____	_____	_____
<b>Behavioral Program:</b> _____	_____	_____	_____	If requesting <b>Psych. Testing</b> , please call 1-800-683-2300 to discuss with UW Behavioral Health.

PCP Name: \_\_\_\_\_ Release to PCP:  Yes  No

PCP Contacted:  Yes  No

If follow-up treatment plan, **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE. FOR UWBH AUTHORIZATION AND COMMUNICATION.**

Axis I Dx      No. of Visits      Begin Date      End Date      Authorization No.      Consultant: \_\_\_\_\_

Date: \_\_\_\_\_

Comments:

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# University of Wisconsin Behavioral Health Follow-Up Outpatient Treatment Request

Date Faxed: \_\_\_\_\_

Page: \_\_\_\_\_ of \_\_\_\_\_

Member or Subscriber Number: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  PPIC  UNITY

Provider's Name: \_\_\_\_\_ Panel Provider?  Yes  No Date of Last Visit: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**DSM IV Diagnosis Codes:** (Rank Axis I diagnoses according to treatment focus. Use DSM IV Codes where applicable.)

AXIS I	AXIS II	AXIS III	AXIS IV (List stressors)	AXIS V (GAF) (Current/Past Year)
_____	_____	_____	_____	_____ / _____
_____	_____	_____	_____	_____ / _____

**Functional Impairments:** Scale: (mild) 1 2 3 4 5 (incapacitating)

Personal/Individual: \_\_\_\_\_ Family/Significant Other: \_\_\_\_\_ Social/Interpersonal: \_\_\_\_\_ Work/School/Other: \_\_\_\_\_ AODA Issues \_\_\_\_\_

**Continuation of care:** Indicate **1)** Reasons for lack of resolution/improvement **2)** Targeted specific measurable impairments **3)** Specific Outcome goals

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Providers Involved: \_\_\_\_\_

Medications: \_\_\_\_\_ Prescribed by: \_\_\_\_\_

Are there other family members receiving treatment by P+ or Unity Provider? If so, who? \_\_\_\_\_

List the number of visits and identify duration wanted for each intervention which will address the impairment being treated.

Intervention	No. of Visits	Begin Date	End Date	Other (Specify):
<b>Individual Rx:</b> _____	_____	_____	_____	_____
<b>Conjoint Rx:</b> _____	_____	_____	_____	
<b>Family Rx:</b> _____	_____	_____	_____	
<b>Group Rx:</b> _____	_____	_____	_____	
<b>Behavioral Program:</b> _____	_____	_____	_____	_____
<b>PCP Name:</b> _____	_____	_____	_____	

If requesting **Psych. Testing**, please call 1-800-683-2300 to discuss with UW Behavioral Health.

Release to PCP:  Yes  No PCP Contacted:  Yes  No

If follow-up treatment plan, **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE. FOR UWBH AUTHORIZATION AND COMMUNICATION.

Axis I Dx	No. of Visits	Begin Date	End Date	Authorization No.	Consultant: _____
_____	_____	_____	_____	_____	Date: _____

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# University of Wisconsin Behavioral Health Psychiatrist Outpatient Treatment Request

Initial Request

Physicians Plus

Today's Date: \_\_\_\_\_

Follow-up Request

UNITY

Last date patient seen by you: \_\_\_\_\_

Frequency of past visits: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Member #: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Provider#: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_ Provider Fax Number: \_\_\_\_\_

**Diagnosis: (Rank Axis I diagnoses according to treatment focus. Use DSM IV Codes where applicable.)**

<b>AXIS I:</b>	<b>AXIS II:</b>	<b>AXIS III:</b>	<b>AXIS IV: (list stressors)</b>	<b>AXIS V (GAF)</b>
_____	_____	_____	_____	_____/_____ (current/past year)

**SYMPTOMS (check all that apply)**

- Change of Appetite     Irritable     Psychotic Symptoms     Work/School Performance Affected     ADD/ADHD
- Change in Sleeping     Anxiety     Behavioral Problems     Change in Concentration     Suicidal/Self-Destructive
- Abnormal Mood     Depression     Thought Disorder     Diminished Pleasure Capacity
- AODA (specify) \_\_\_\_\_     Other: (specify) \_\_\_\_\_

**Medication Management:**

Will you do?

YES     NO

Will PCP do?

YES     NO

Medication Only

Stable

Titrating

Specify Medications: \_\_\_\_\_

Will you eventually be referring medication management to PCP?

Immediately

Eventually

**Recommending Psychotherapy ?**

Yes

No

Current Therapist ?

Yes

No

If yes, what is/should be focus of treatment? \_\_\_\_\_

Will you be doing ?

Yes

No

If you are recommending a specific PPIC or Unity provider, please identify: \_\_\_\_\_

Additional information: \_\_\_\_\_

**PROVIDER REQUESTED SERVICES**

<u>Intervention</u>	<u>No. of Visits</u>	<u>Begin Date</u>	<u>End Date</u>	<u>Other (specify):</u> _____
Medications	_____	_____	_____	_____
Psychotherapy	_____	_____	_____	_____

Ancillary services recommended not requiring precertification: \_\_\_\_\_

Name of

PCP: \_\_\_\_\_

Release to PCP:  Yes     No

PCP Contacted:  Yes     No

IF follow-up treatment plan, **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**UWBH Authorization & Communication**

<u>Axis I Dx</u>	<u>No. of Visits</u>	<u>Begin Date</u>	<u>End Date</u>	<u>Authorization No.</u>	<u>Consultant</u>	<u>Date</u>
_____	_____	_____	_____	_____	_____	_____

Comments: \_\_\_\_\_

## Behavioral Health/Chemical Dependency Section

### BEHAVIORAL HEALTH BENEFITS

	<i>OUTPATIENT</i>	<i>TRANSITIONAL</i>	<i>INPATIENT</i>	<i>TOTAL</i>
<b>State/WPE</b>	<b>BH Dx:</b> No limit <b>AODA Dx:</b> \$1800/yr	<b>BH Dx:</b> No limit <b>AODA Dx:</b> \$2700/yr	<b>BH Dx:</b> No limit <b>AODA Dx:</b> \$6300/yr	AODA only: Combined not to exceed \$7000/yr  <b>\$ paid for BH services apply toward AODA limit</b>
<b>GTE</b>	<b>BH Dx:</b> 20 visits <b>AODA Dx:</b> \$1800/yr	<b>BH Dx:</b> 18 days/yr <b>AODA Dx:</b> \$2700/yr	<b>BH Dx:</b> 12 days/yr <b>AODA Dx:</b> \$6300/yr	<b>AODA only:</b> Combined total \$6300/yr
<b>Med Supps</b>	No limit	No limit	After Medicare pays 190 days	<b>NOTE:</b> No changes
<b>Conversion</b>	No benefit	No benefit	No benefit	<b>NOTE:</b> No changes
<b>All Others</b> Copay 10 Copay 15 Copay 20 Copay 35 \$100 Deductible \$250 Deductible Custom HMO HealthShare	<b>BH Dx &amp; AODA Dx:</b> 20 visits/yr. See combined total	<b>BH Dx &amp; AODA Dx:</b> 18 days/yr. See combined total	<b>BH Dx &amp; AODA Dx:</b> 12 days/yr. See combined total	<b>AODA only:</b> Combined total \$6300/yr  <b>The AODA visits/days will also be counted and applied toward the BH day/visit totals</b>
<b>Off Panel</b>	<b>BH Dx &amp; AODA Dx:</b> 20 visits/yr. See combined total @ 10% coinsurance	<b>BH Dx &amp; AODA Dx:</b> 18 days/yr. See combined total @ 10% coinsurance	<b>BH Dx &amp; AODA Dx:</b> 12 days/yr. See combined total @ 10% coinsurance	<b>AODA only:</b> Combined total \$7000/yr  <b>The AODA visits/days will also be counted and applied toward the BH day/visit totals</b>

Outpatient labs will apply toward the MEDICAL benefit.

All Inpatient detox will be applied toward AODA benefits - all plans.

Visit = Individual, group, or family psychotherapy and medication check(s)

\*Benefits Effective 01/01/1999