Provider Procedures for Authorization, Care Management Review and Claims

General Information

- All treatment services are subject to review for medical necessity and appropriateness of care.
- Pre-service certification is offered as a courtesy to establish medical necessity.
- Special outpatient services (such as psychological testing, ECT, TMS) require pre-authorization review in writing or by telephone with an IBH Care Manager.
- All communication regarding patient care must include the patient's full name and date of birth.
- After the initial set of sessions, please contact an IBH Care Manager if frequency of visits will exceed once per week.
- IBH values partnership with providers in an effort to provide exceptionally high levels of administrative responsiveness and clinical quality. Providers are encouraged to discuss treatment with an IBH Care Manager.

IBH Treatment Authorization Provider Copy

- Please note the type of service and the beginning and ending dates of the treatment authorization period on the attached authorization.

Treatment Authorization Request

- If treatment will continue beyond the initial authorized sessions, submit the enclosed TREATMENT PLAN form before the initial certification expires to request additional sessions. After Care Management review, a specific number of appropriate service units will be authorized. Treatment plans must be completed in full. You may attach supporting clinical documentation.
- Blank forms for continued treatment can be found on the IBH website on ibhsolutions.com/providers.

Filing a Claim

- When you file your claim for reimbursement, ***please bill your standard rates*** (not discounted or IBH contracted rates). Claims can be mailed or faxed and can be submitted on a professional invoice or current health insurance claim form.

Mail or Fax All Correspondence to:

Integrated Behavioral Health
P.O. Box 30018
Laguna Niguel, CA 92607-0018

Phone: 800-395-1616
Confidential Fax: 714-556-5430
Website: ibhsolutions.com

IBH POPULATION HEALTH SOLUTIONS

Request for Continued Medication Management Treatment Plan

Report Date: _____

Patient Name: _____ DOB: _____ Sex: M F O: _____

Insured Name: _____ Employer: _____ Insured #: _____

Practitioner Name: _____ License #: _____ License Type: _____

_____ ( ) _____

Address City State Zip Phone

1. TREATMENT HISTORY (*For current episode*)

a. Date this treatment began: _____

b. Date of last treatment pre-cert request: _____

RECEIVED BY IBH

(FOR OFFICE USE ONLY)

2. (a) DSM-5 / ICD-10 DIAGNOSIS **(b) SYMPTOMS** (*must justify principal diagnosis*)

	Code	Description
A. I	_____	_____
B. I	_____	_____
C. I	_____	_____
D. I	_____	_____
E. I	_____	_____
F. I	_____	_____

3. REQUESTED SERVICES

	Session to Date	Requested Sessions	Frequency (*circle week or month*)	Requested Cert Period (Dates) From	To
Pharmacotherapy Mgmt. (99213)	_____	_____	(at _____/week/month)	_____	_____
Therapy w/meds Mgmt. *	_____	_____	(at _____/week/month)	_____	_____

*(90833/36 Add-on) NOTE: PLEASE ATTACH DETAILED RATIONALE FOR REQUESTING EXTENDED SERVICES INCLUDING SPECIFIC BEHAVIORAL GOALS AND STRATEGIES.

4. PROGRESS

a. Overview of Progress since last report (*Please document any significant change in functioning*):

b. Rationale for medications changes and response:

IBH POPULATION HEALTH SOLUTIONS

5. MEDICATIONS Patient Name:_____

Meds Discontinued	Meds Started		Meds Continued	
Name	Name	Dosage/Frequency	Name	Dosage/Frequency

If patient is on lithium, carbamazepine or valproic acid, please give the most recent blood level:

Medication: _____ Blood level: _____ Date: _____

Medication: _____ Blood level: _____ Date: _____

6. MEDICATION TREATMENT GOALS **MEDICATION FOR EACH GOAL**

1. GOAL:_____ _____

AS MEASURED BY: _____ _____

2. GOAL:_____ _____

AS MEASURED BY: _____ _____

3. GOAL:_____ _____

AS MEASURED BY:_____ _____

(NOTE: All services must be pre-certified by each provider separately)

7. OTHER SERVICE PROVIDERS

a. Other providers be involved in treatment. License Type: ☐ M.D. ☐ Ph.D./Psy.D. ☐ LMFT/LCSW

b. Please indicate Provider Name: _____
(Please Print)

c. Services to be provided: ☐ Medications ☐ Marital/Family Therapy ☐ Individual Therapy ☐ Evaluation/Assessment

☐ Group ☐ Other _____ Document date of last contact with this provider: _____

8. TERMINATION PLAN

a. Anticipated duration of medication management: _____

b. Prognosis *(based on what indicators?)*: ☐ Good ☐ Fair ☐ Poor _____

_____

c. Compliance with medication: ☐ Good ☐ Fair ☐ Poor
Plans to address problems with compliance, if it is not rated " Good": _____

_____

9. PROVIDER NAME *(please print)*: _____

I acknowledge that I am personally providing the treatment services requested herein (*with the exception of those stated in item 9*).

_____ _____
Provider's Signature **Date**

Return to: IBH P.O. Box 30018 Laguna Niguel, CA 92607-0018
Phone: 800-395-1616 | Confidential Fax: 714-556-5430