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

INTEGRATED BEHAVIORAL HEALTH (IBH)
REQUEST FOR CONTINUED MENTAL HEALTH TREATMENT

RECEIVED BY IBH

(FOR OFFICE USE ONLY)

Patient Name: _____ DOB: _____ Sex: M F O _____ Insured Member #: _____

Insured Name: _____ Employer: _____ Report Date: _____

Practitioner Name: _____ License# / State: _____ License Type: _____ Tax ID #: _____

Practitioner Address: _____ City/State/Zip: _____ Phone #: _____

A. HISTORY OF CURRENT EPISODE: Date this episode began: _____ Type and amount of treatment for this episode to date: _____

B. PRESENTING PROBLEMS (Patient's Stated Reason For Treatment):

C. PRESENTING SYMPTOMS (Symptoms that justify Current Diagnoses):

D. BRIEF HISTORY (Relevant to Presenting Problems and Symptoms):

E. PROGRESS MADE (since first session or last report)

F. CURRENT DSM-5/ICD-10 DIAGNOSES (Include Code AND Description):

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

G. PATIENT HISTORY

1. Is patient recently (< 30 days) discharged from a higher level of care? ☐ No ☐ Yes
   ☐ acute inpatient ☐ residential ☐ day treatment
2. Is the patient on psychiatric or chemical dependency disability? ☐ No ☐ Yes
3. Has the patient had a medical examination within the past 6 months? ☐ No ☐ Yes
4. Has there been a recent significant deterioration or loss of functioning? ☐ No ☐ Yes

   Explain:

H. REQUESTED SERVICES:

	Sessions Completed To Date	# Sessions Requesting	Frequency	Requested Cert Period (Dates)[2] From[1]	To
Individual Therapy (90834)	_____	_____	(at____x/ ☐week ☐month)	_____	_____
Group Therapy (90853)	_____	_____	(at____x/ ☐week ☐month)	_____	_____
Family/Therapy 90846/47)	_____	_____	(at____x/ ☐week ☐month)	_____	_____
Med. Mgmt. MD/NP Only (99213)	_____	_____	(at____x/ ☐week ☐month)	_____	_____
Other: _____	_____	_____	(at____x/ ☐week ☐month)	_____	_____

[1]*Pre-certification will begin from the date IBH receives this Treatment Plan.*
(Treatment Plan may be faxed to: 714-556-5430)

[2]*NOTE: For end of benefit year requests, please divide requested sessions between end of current year and beginning of next year.*

NOTE: Please call IBH Care Management at (800) 395-1616 if:

1) A medication evaluation referral is needed.
2) *More than one visit per week is requested
3) *Psychological Testing is requested
4) *Biofeedback is requested
5) A higher level of care or a major change in treatment plan is indicated.
6) A referral to another IBH network provider is being requested.

***To request pre-authorization for these services, the provider MUST call for review with an IBH Clinical Care Manager or fax written request at 714-556-5430**

IBH Request For Continued Mental Health Treatment

I. MEDICATIONS (ALL PROVIDERS to document) Patient: _____

CURRENT MEDICATIONS

Name	Dosage/Frequency	Name	Dosage/Frequency
1.		3.	
2.		4.	

List prescribing physician if you are not the prescriber: _____

If no medications are prescribed, have you discussed with patient the possibility of using medication? ☐ No, meds not indicated ☐ Yes, patient refuses

J. CURRENT RISK ASSESSMENT:

Harm to Self ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent w/means *If risk exists: Patient is able to contract not to harm:* ☐ *Self* ☐ *Others*
Harm to others ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent w/means Other Safety issue details: _____
Impulse control: ☐Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive _____

Current physical or sexual abuse or child/elder neglect? ☐ Yes ☐ No
If "Yes" patient is: ☐ Victim ☐ Perpetrator Legally reported? ☐ Yes ☐ No

Alcohol use: ☐ Not Significant ☐ Abuse ☐ Dependence ***Specify quantity, frequency, and date of last use:***
Substance use: ☐ Not Significant ☐ Abuse ☐ Dependence _____

K. TREATMENT GOALS AND STRATEGIES *(Specific, Observable, and Measurable)*

1) TREATMENT GOAL: _____
PROGRESS IS MEASURED BY: _____ TARGET DATE: _____
TREATMENT STRATEGIES / INTERVENTIONS USED: _____

2) TREATMENT GOAL: _____
PROGRESS IS MEASURED BY: _____ TARGET DATE: _____
TREATMENT STRATEGIES / INTERVENTIONS USED: _____

3) TREATMENT GOAL: _____
PROGRESS IS MEASURED BY: _____ TARGET DATE: _____
TREATMENT STRATEGIES / INTERVENTIONS USED: _____

(if needed, please use separate sheet for additional goals, strategies, or to document progress made for this patient)

Treatment Plan discussed with patient, guardian or other legal representative, or parent of a minor? ☐ Yes ☐ No

L. TREATMENT COORDINATION

a. Will other providers be involved in treatment? ☐ No ☐ Yes License Type: ☐ MD/DO ☐ PhD/PsyD ☐ LMFT/LCSW/LPC
b. Services to be provided by others: ☐ Medications ☐ Mar/Fam Therapy ☐ Individual Therapy ☐ Other _____
c. Document date of your **last contact** to coordinate treatment with other provider(s): _____
d. Adjunctive/Community referrals utilizing (support groups, etc.): _____
e. Treatment coordinated with PCP? ☐ Yes ☐ No ☐ N/A

M. TERMINATION PLAN

a. Anticipated length of medically necessary treatment: ☐ 1 - 3 mos ☐ 3 - 6 mos ☐ > 6 mos Est. Date of Termination Session: _____ Est. # Sessions to Complete Treatment: _____

(if > 6 mos, document patient conditions that justify long term treatment that is medically/clinically necessary):

b. Prognosis: ☐ Good ☐ Fair ☐ Poor *Based on what indicators?* _____

N. PROVIDER NAME *I acknowledge that I am personally providing the treatment services requested herein, and that I am independently licensed:*

X _____ _____
Provider Signature Date License # Prirt Provider Name

Return to: **Integrated Behavioral Health**
Care Management Services
P. O. Box 30018
Laguna Niguel, CA 92607-0018
or
CONFIDENTIAL Care Management fax at:
(714) 556-5430