Mental Health Care Services Request For Additional Visits

TUFTS Health Plan
www.tuftshealthplan.com/providers
Mental Health Department - 800-208-9565

Mail To: Tufts Health Plan, 705 Mt. Auburn Street, Watertown, MA 02472, Attention: Psychiatric Reviewer, or
Submit Electronically: at www.tuftshealthplan.com or
Interactive Voice Response: at 800-208-9565.

*****Do Not Fax This Form*****

This form is for use by in-plan providers only. Complete all sections of this form. Please print.

Patient Name: _____

Age:_____ Date of Birth:_____ Tufts HP ID Number (include suffix): ☐☐☐☐☐☐☐☐☐-☐☐

Treating Clinician: _____ ____ Group/Agency Name: _____

Group Number:☐☐☐☐☐☐ If NOT in a group practice, give individual provider number:☐☐☐☐☐☐

Address: _____

Telephone: _____

Number of Visits Requested: _____ Have you communicated with PCP? ☐Yes ☐No

Type of Treatment Requested: ☐ individual ☐ couples ☐ family ☐ group

Visit Frequency: ☐ twice weekly ☐ weekly ☐ twice monthly ☐ monthly ☐ less than monthly

Months in Current Treatment: ☐ less than 3 mos. ☐ 3-6 mos. ☐ 6-12 mos. ☐ 12-24 mos. ☐ greater than 24 mos

DIAGNOSIS currently being treated:

Axis I code: _____ **Axis I description**:_____

Axis II: _____ **Axis III:** _____

Axis IV:_____ **Medical condition relevant to current treatment** ☐ Yes ☐No

Axis V: Current GAF: _____ **Highest:** _____**Lowest**: _____

SEVERITY OF CURRENT FUNCTIONAL IMPAIRMENTS: (please circle) 0= none reported 1=mild 2=moderate 3=severe

Work/School Impairment: 0 1 2 3 Self Care Impairment: 0 1 2 3 Social Impairment: 0 1 2 3

Family/Marital Impairment: 0 1 2 3

SEVERITY OF CURRENT SYMPTOMS: (Please circle) 0= none reported 1=mild 2=moderate 3=severe

Depressed Mood: 0 1 2 3 Anxiety: 0 1 2 3 Sleep Disturbance: 0 1 2 3 Impulsivity: 0 1 2 3

Inattention: 0 1 2 3 Appetite Disturbance: 0 1 2 3 Binging: 0 1 2 3 Purging: 0 1 2 3 Restricting: 0 1 2 3

Psychosis: 0 1 2 3

Current Suicidality: ☐ none reported ☐ ideation ☐ plan

Current Homicidality: ☐ none reported ☐ ideation ☐ plan

Current Substance Abuse: ☐ none reported ☐ daily use ☐ weekly use ☐ monthly use ☐ episodic use

History of Suicide Gestures/Attempts: ☐ None reported ☐ Past mo. ☐ Past 6 mos. ☐ Past yr. ☐ Over 1yr. ago

History of Assaultiveness: ☐ None reported ☐ Past mo. ☐ Past 6 mos. ☐ Past yr. ☐ Over 1yr. ago

History of Psychiatric Hospitalization: ☐ None reported ☐ Past mo. ☐ Past 6 mos. ☐ Past yr. ☐ Over 1yr. ago

History of Substance Abuse Admissions: ☐ None reported ☐ Past mo. ☐ Past 6 mos. ☐ Past yr. ☐ Over 1yr. ago

Current Medication Use: ☐ No Psychotropic medications ☐ Anti-depressant ☐ Anti-anxiety ☐ Psycho-stimulant ☐ Hypnotic/sedative ☐ Mood stabilizer/Anti-convulsant ☐ Anti-psychotic ☐ Other

Has a psychopharmacological consultation been sought? ☐ **yes** ☐ **no**

Progress since start of treatment: ☐ None ☐ Minimal ☐ Moderate ☐ Substantial ☐ Symptoms stabilized

Progress since last report: ☐ 1st report ☐ None ☐ Minimal ☐ Moderate ☐ Substantial ☐ Symptoms stabilized

Does member's condition meet the Criteria for Medical Necessity? ☐ **Yes** ☐ **No** ☐ **Uncertain**

Medical Necessity Criteria are on the reverse side of this form.

Optional Provider Comments: _____

Signature of Treating Clinician: _____ **Discipline:**_____ **Today's Date:**_____

FOR THP USE ONLY

Reviewer Name: _____ Visits Authorized: _____ Date: _____ Time:_____

Provider called on Date _____Time: _____ Initials: _____ 9/2006

MENTAL HEALTH CARE SERVICES REQUEST FOR ADDITIONAL VISITS

Mail To: Tufts Health Plan, 705 Mt. Auburn Street, Watertown, MA 02472, Attention: Psychiatric Reviewer, or **Submit Electronically**: at **www.tuftshealthplan.com** or by **Interactive Voice Response at: 800-208-9565**

PLEASE DO NOT FAX THIS FORM

When completing this form, please consider the following:

1. **This form is to be used by contracting providers only.** All out of plan providers should contact the Mental Health Department at (800) 208-9565.
2. **Form must be completed by provider rendering services.**
3. Determinations are based on the information provided on this form. Please provide any additional information you think is relevant in making a coverage determination.
4. **Please be aware of the member's benefit. Claims for visits beyond that limit, even if authorized, will not be covered.**
5. No authorization is required for medication management visits (90862) or for PPO members.
6. Please contact the member's PCP for authorizations for Tufts Health Plan Medicare Preferred HMO members.
7. **Complete all parts as clearly and specifically as possible. Omissions may result in the form being returned for completion or clarification.**
8. Please use **BLACK** ink when completing this form.
9. If authorized, the referral will begin the day the form is received.
10. If it has been at least 12 months since the start date of your last referral, or this is a request for new treatment, authorization can be obtained through the Tufts Health Plan telephone interactive voice response system (IVR) at (800) 208-9565.

MEDICAL NECESSITY CRITERIA FOR OUTPATIENT MHSA TREATMENT

The following criteria must each be met to establish the Medical Necessity of a proposed outpatient MHSA treatment:

1. Clinical data provides clear evidence of signs and symptoms consistent with a mental health or substance abuse illness as defined in DSM-IV for which outpatient treatment has been shown to be an effective treatment.
2. Clinical data provides clear evidence that the symptoms of the patient's mental health or substance abuse illness are active, resulting in substantial impairment in daily functioning.
3. There is a clear treatment plan, measurable goals and approaches that address the signs and symptoms of the patient's mental health or substance abuse illness and is consistent with current professional practice standards.
4. Clinical data indicates that either:
    a. The member is making progress towards symptom reduction, or
    b. The member's condition has stabilized and continued treatment at a maintenance level is needed to sustain the current level of functioning**.**
5. There is no less intensive or more appropriate level of service which can be safely and effectively provided.

THANK YOU FOR WORKING WITH TUFTS HEALTH PLAN