Select Health of South Carolina

Healthy Connections

Community Support Service (CSS) Authorization Request Form

Private Rehabilitative Behavioral Health Providers

Please print clearly — incomplete or illegible forms will delay processing. Please return to Select Health Behavioral Health Utilization Management at **1-888-796-5521**. For assistance contact **1-866-341-8765**.

Member information		
Patient name:		Date of birth:
Legal guardian:	Medicaid/health plan ID number:	Last authorization number (if applicable):

Provider information			
Provider name:	☐ In network ☐ Out of network ☐ In credentialing process		
Group/agency name:	Provider credential: ☐ MD ☐ PhD ☐ LIP ☐ CAC ☐ NP ☐ Other:		
Physical address:		Phone:	Fax:
Medicaid/provider/National Provider Identifier (NPI) number:		Contact name:	

DSM diagnosis

Primary diagnosis _____ Secondary diagnosis _____ Medical diagnosis _____

Primary care physician (PCP) information and collaboration

Has information been shared with the PCP or other providers regarding:

The initial evaluation and treatment plan? ☐ Yes ☐ No (explain): _____

The updated evaluation and treatment plan? ☐ Yes ☐ No (explain): _____

Other behavioral health provider name and date last notified: _____

PCP name and date last notified: _____

Type of request: ☐ **Initial** ☐ **Continued stay** (member has current and active authorization for services)

Please attach the following to the authorization request:

☐ Clinical assessment ☐ Treatment plan ☐ Parenting stress index (PSI), child behavior check list (CBCL), child and adolescent service intensity instrument (CASII) (as applicable) ☐ Parent/caregiver/guardian agreement to participate in CSS (as applicable for members ages 15 years and younger)

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	1 None	2 Low	3 Moderate	4 High	5 Extreme
Suicidal					
Homicidal					
Assault/violent					

Medications

Is member prescribed medications? Yes No Prescribing physician(s) name(s): _____

Is member compliant with medications? Yes No

Please list medications and dosages: _____

Community-based RBHS treatment request (please check services being requested)

Treatment start date: _____ (Cannot be a date prior to the date of the Diagnostic Assessment.)

Behavior Modification (BMod): face-to-face services to alter patterns of inappropriate behaviors for members ages 0 – 21. The Behavior Modification Plan (BMP) is required with each request.

Service code: **H2014** Number of units: _____ Each: week month _____

Psychosocial Rehabilitation Services (PRS): face-to-face services that are time limited and focused on skill building.

Service code: **H2017** Number of units: _____ Each: week month _____

Family Support (FS): face-to-face service to help the family/caregiver serve as an engaged member of the treatment plan and services.

Service code: **S9482** Number of units: _____ Each: week month _____

Therapeutic Childcare Services (TCC): face-to-face service to assist children with severe emotional and/or behavioral issues (for children under the age of 6 only).

Service code: **H2037** Number of units: _____ Each: week month _____

Community Integration Services (CIS): face-to-face service to assist adult members diagnosed with SPMI and/or co-occurring MH/SUD.

Service code: **H2030** Number of units: _____ Each: week month _____

Assertive Community Treatment (ACT): face-to-face service providing intensive rehabilitative mental health services for members with severe mental illness (SMI).

Service code: **H0040** Number of units: _____ Each: week month _____

Therapeutic Foster Care (TFC) Treatment request ONLY. If completing this section, do not request PRS H2017.

Treatment start date for Therapeutic Foster Care: _____

Therapeutic Foster Care (TFC): TFC and FS services provided by a credentialed TFC provider.

Service code: **S5145** Level 1: No modifier Level 2: TF Modifier Level 3: TG Modifier

Treatment start date for **S9482**: _____ (Cannot be a date prior to the date of the Diagnostic Assessment.)

Service code: **S9482** Number of units: _____ Each: week month

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Please complete this section for initial authorization requests or skip below to page 6 for continued stay authorization requests.

1. Treatment plan.

Please clearly indicate the service (e.g., PSR, BMod, FS) and what interventions (e.g., anger management, social skills, etc.) will be provided under each service requested. Please specify, for each intervention, the duration and frequency of delivery per week (e.g., 30 minute sessions twice per week) and the number of weeks needed to complete one cycle of intervention (e.g, social skill training lasts 12 weeks, relaxation training and practice sessions last eight weeks, etc.).

For each problem and goal, fill in the appropriate information below it.	**CSS service**	**Type of intervention**	**Duration** (minutes) **and frequency** (sessions per week)	**Length of intervention** (weeks needed to complete one cycle)	**Who will provide the intervention?**
Problem/goal					
Problem/goal					
Problem/goal					
Problem/goal					
Problem/goal					

2. The member is unable to be managed at a less intensive level of care safely within the last week.

☐ Yes ☐ No

3. Is the member currently in short-term respite or any other mental health/substance use disorder service(s)?

☐ Yes ☐ No If yes, explain: _____

4. The member has displayed any of the following within the last week:

- ☐ Age-appropriate assessment tool (indicate below):
  - ☐ PSI of 81st percentile or above (age birth – 1.5 yr)
  - ☐ CBCL borderline in syndrome and DSM (age 1.5 – 5 yr)
  - ☐ CASII composite score of 17+ (age 6 – 18 yr)
- ☐ Angry outbursts/aggression that is unmanageable
- ☐ Arrest/confirmed illegal activity
- ☐ Cruelty to animals
- ☐ Daredevil and/or impulsive behaviors
- ☐ Delusions/hallucinations
- ☐ Destruction of property
- ☐ Disorganized thoughts, speech, or behavior
- ☐ Encopresis and feces smearing
- ☐ Fire setting
- ☐ Hypomanic or hypermanic symptoms increased
- ☐ Persistent violation of court orders
- ☐ Running away for more than 24 hours
- ☐ Self-injurious behaviors
- ☐ Sexually inappropriate/ aggressive/abusive
- ☐ Suicidal ideations

5. Have the behaviors been persistent for at least six months? ☐ Yes ☐ No

6. Are the behaviors expected to continue longer than one year without treatment? ☐ Yes ☐ No

7. The member has had unsuccessful treatment history (lack of improvement) in any of the following within the last month (check all that apply):

- ☐ Community support services
- ☐ Multiple admissions within a psychiatric inpatient, partial hospitalization program (PHP), or intensive outpatient (IOP) in any combination
- ☐ Outpatient therapy (OPT) services
- ☐ Psychiatric inpatient admissions
- ☐ Psychiatric PHP admissions
- ☐ Residential treatment and/or therapeutic group home
- ☐ Substance use disorder OPT/residential
- ☐ Therapeutic foster care
- ☐ None (explain below)

If the member has not had any of the above services in the past month, please explain the reason core treatment services are not clinically appropriate for this member:

_____

8. The member's support system is any of the following within the last six to 12 months (check all that apply):

- ☐ Abusive
- ☐ High risk environment (please specify what makes it high risk): _____
  _____
- ☐ Intentionally sabotages treatments
- ☐ Involved in treatment and treatment planning
- ☐ Unable to ensure safety
- ☐ Unable to manage the intensity of the member symptoms without a structured program
- ☐ Unavailable

9. The member's living environment (please check one):

- ☐ Member is living in a safe environment
- ☐ Member is emancipated/estranged from family and/or lives independently and lacks independent living skills
- ☐ Member has demonstrated intolerance for family environment or adult authority and needs out of home placement (child/adolescent)
- ☐ Member is at risk of out of home placement, homelessness and/or an inpatient psychiatric hospitalization as evidenced by (please explain): _____

_____

_____

10. The member has severe impairment as listed below (check all that apply). These impairments need to be documented on the member's assessment:

- ☐ Activities of Daily Living (ADLs)
- ☐ Community living
- ☐ Social relationships
- ☐ Family relationships
- ☐ School performance

11. Additional clinical information to support the medical necessity of the requested services:

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Please complete this section for continued stay authorization requests.

Last authorization number:	Services authorized	Units authorized per service	Units used per service in last authorization	Reason(s) for unused units within last authorization period
Dates of last authorization:				

1. Within the last month the member has experienced and/or displayed the following (check all that apply):

- ☐ Anxiety and/or depressed mood with associated symptoms
- ☐ Disruptive behaviors
- ☐ Has been arrested and/or violated legal probation
- ☐ Has had an after-hours crisis
- ☐ Has interpersonal conflicts that can include angry outbursts, physical altercations, is hostile or intimidating to support system, manipulates, and/or has poor boundaries
- ☐ Has ongoing isolation and/or inappropriate social behaviors
- ☐ Has school or employment problems resulting in suspensions/expulsion or risk of loss of employment
- ☐ Hypomanic symptoms
- ☐ Is neglecting ADLs and/or needs monitoring for ADLs
- ☐ Obsessions/compulsions
- ☐ Psychiatric medication noncompliance
- ☐ Psychosis
- ☐ PTSD or history of trauma
- ☐ Suicidal and/or homicidal ideations (with or without intent)

2. The member is receiving the following services:

Treatment plan: please clearly indicate the service (e.g., CPST, BMod, FS) and what interventions (e.g., anger management, social skills, etc.) will be provided under each service requested. Please specify for each intervention the duration and frequency of delivery per week (e.g., 30 minute sessions twice per week) and the number of weeks needed to complete one cycle of intervention (e.g., social skill training lasts 12 weeks, relaxation training and practice sessions last 8 weeks, etc.).

For each problem and goal, fill in the appropriate information below it.	**CSS service**	**Type of intervention**	**Duration** (minutes) **and frequency** (sessions per week)	**Length of intervention** (weeks needed to complete one cycle)	**Who will provide the intervention?**
Problem/goal					
Problem/goal					
Problem/goal					
Problem/goal					
Problem/goal					

2a. How do the member's behaviors/symptoms compare to the last authorization request for these services?

2b. What will be done differently from the last authorized treatment period?

3. Additional clinical information to support the medical necessity of the requested services: