

Beacon Health Options: eServices Training Guide Outpatient Services

**eSERVICES** | w ww.beaconhealthoptions.com | July 2017 Beacon Health Strategies is a Beacon Health Options, Inc. company.

### **Outpatient Authorization**

Member:	
site state	
City, State:	
DOB:	
Clinician Details	
Clinician Name:	
Clinician Phone #:	

## **Clinician Name**

Enter name of the person who will be providing the treatment.

# **Clinician Phone #**

What number can we use to contact this clinician if we have questions about this authorization request.

(Select a value)	Individual/ Family Therap
○ 30 days ○ 90 days ● 180 days ○ Other	Group Therapy
4/8/2017	
	•
12	
	<ul> <li>○ 30 days ○ 90 days ● 180 days ○ Other</li> <li>4/8/2017</li> <li>Ⅲ</li> <li>12</li> </ul>

## Type of Benefit/Service requested

Please select either Individual/Family Therapy or Group Therapy

#### Hint

Remember, psychiatric diagnostic/medication monitoring (90791, 90792, 99211-99215) do not require prior authorization and do not count towards initial encounters (IEs).

#### Sessions over the next

Select the date range you want this authorization to cover.

### From date

Select the date you want this authorization to begin.

### **Site of Service**

Select the site in which treatment will be provided to the member.

## **Total # of Visits Requested**

Please be mindful to request a reasonable number of visits.

#### **Outpatient Authorization**

Member:	
City, State:	
DOB:	
Clinician Details	
Clinician Name:	
Clinician Dhone #	

### **Clinician Details**

Your name and contact information.

#### **Outpatient Authorization**

Existing Reviews	now		
Current Psychotropic Medications Are psychotropic medications being prescribed?	Unknown	Unknown No Yes	

## **Existing Reviews**

You can ignore this field.

## **Current Psychotropic Medications**

It is very important to ask member if they are currently on any psychotropic medications.

Have you communicated with the member's prescriber of psychotropic drugs? *	○ Yes ○ Member Declined ○ N/A Member not on Medication	○ No ○ N/A Provider is the prescriber n
Have you communicated with the member's PCP? *	⊖Yes ⊖No ⊖Member Decline	d
Have you documented the communication or member declination? *	$\bigcirc$ Yes $\bigcirc$ No $\bigcirc$ N/A I did not con	itact PCP
Have you been in communication with other BH providers for this member? *	⊖Yes ⊖No ⊖Member Decline	d $\bigcirc$ N/A There are no other BH providers
If Yes, please indicate the type of BH provider		

# **PCP/BH Provider Contact**

This section is very important in completing the authorization request. Collaboration with member's PCP, Prescriber or BH provider is important to the member's continuity of care. This information is required in order to complete the authorization request. Choose the option which best describes your actions.

Diagnosis	DSM-5		ICD-10		ICD-9	
rimary Diagnosis: *	Major depressive disorder, Recurrent episode, In full remissi	•	F33.42	•	296.36	_
dditional BH/SA Dx's:	Choose an Item	•	Choose an Item	•	Choose an Item	
	Choose an Item	•	Choose an Item	•	Choose an Item	
	Choose an Item	•	Choose an Item	-	Choose an Item	
	DESCRIPTION requires at least 6 characters to search Description		CODE requires at lea	ist 3 c	haracters to search	
	DESCRIPTION requires at least 6 characters to search Description	,	CODE requires at lea	ist 3 c	haracters to search	
edical Diagnosis 1:	DESCRIPTION requires at least 6 characters to search Description		CODE requires at lea	nst 3 c	haracters to search Code	
edical Diagnosis 1: Iedical Diagnosis 2:	DESCRIPTION requires at least 6 characters to search Description		CODE requires at lea	est 3 c	haracters to search Code	
ledical Diagnosis 1: ledical Diagnosis 2: ledical Diagnosis 3:	DESCRIPTION requires at least 6 characters to search Description		CODE requires at lea	est 3 c	haracters to search Code	
edical Diagnosis 1: edical Diagnosis 2: edical Diagnosis 3: edical Diagnosis 4:	DESCRIPTION requires at least 6 characters to search Description		CODE requires at lea	est 3 c	haracters to search Code	
Medical Diagnosis 1: Medical Diagnosis 2: Medical Diagnosis 3: Medical Diagnosis 4:	DESCRIPTION requires at least 6 characters to search Description		CODE requires at lea	ast 3 c	haracters to search	

## **Primary Diagnosis**

Please list all the diagnoses for this member. You can enter the first few letters of the diagnosis and the system will provide you the complete diagnosis name. You must click the "Next" button.

#### Hint

This screen requires that diagnosis be entered in order for you to proceed.

#### Hint

Once you click the "Next" button, the system will automatically enter the ICD-10 and ICD-9 codes.

Existing Reviews	Show
TREATMENT STATUS (Please rate the patient's response to treatme	ent since last review or since start of treatment if this is first report)
Behavioral Symptoms that are focus of treatment	Much Worse Slightly Worse
Ability to perform work/school/household tasks	No Changes Slight Improvement Major Improvement
Other Agency Involvement	AA/NA Court Member First Name Member Last Name OOB Gender
Location of Treatment:	Office Home School Other
Clinical Formulations: (Please limit the total number of characters to 1000 or less)	

## **Treatment Status**

This section provides the Beacon Health Options clinician valuable information about success of treatment so far and other information needed to complete the authorization. Please provide answers to these sections if at all possible.

#### **Clinical Formulation**

Please be concise in this section. This information is extremely valuable in helping the Beacon Health Options clinician understand the trajectory of treatment.

Targeted Behavioral Goal (be specific)	*	
Modality	*	
Progress Update	*	

Targeted Behavioral Goal (be specific)	*	
Modality	*	
Progress Update	*	×

Targeted Behavioral Goal (be specific)	
Modality	
,	
Progress Update	

# **Targeted Behavioral Goals**

Describe treatment goals, including specifics about what behavior(s) you are working on and what outcome(s) you are working towards. Include treatment modality and any updates regarding progress.

RISK ASSESSMENT (Check all that apply)		
Risk Indicators:	Current substance abuse	Fire setting
	Caring for ill family member	Impulsive behavior
	□ Self-mutilation/cutting	Assaultive behavior
	Prior psychiatric inpatient admission	Psychotic Symptoms
	Sexually offending behavior	Coping with significant loss (job, relationship, financial)
	Current family violence (abuse, domestic)	
Other Risk Indicators:		
Suicidality:*	Not Drocont/Suisidality)	
Succurry.	Inot Present(Suicidality)     Isan(Suicidality)	Moons (Suicidality)
	Prior attempt (last 12 months)(	Suicidality)
Homicidality:*		
,	INOT Present (Hornicidality)     Inot Present (Hornicidality)	Means/Homicidality)
	Prior attempt (last 12 months)(	Homicidality)
Rate level of Psychological distress: *	$\bigcirc$ 1 [Minimal] $\bigcirc$ 2 [Mild] $\bigcirc$ 3 [N	Noderate] 04 [Marked] 05 [Severe]
Provider's assessment of current risk of psychiatric hospitalization:*	○1. Minimal ○2. Mild ○3. Mo	derate $\bigcirc$ 4. Marked $\bigcirc$ 5. Severe
If 3 or higher, have you created/ reviewed a crisis plan for this member?	⊖Yes ⊖No ⊖Member Decline	d
If Yes, does the member have a copy?	⊖ Yes ⊖ No	
Member has been in higher level of care in past 12 months?	⊖Yes <sup>®</sup> No	

### **Risk Assessment**

Please complete this section in its entirety. Several of these sections require a response.

### **Risk Indicators**

Current risk indicators for the member.

### Suicidality / Homicidality

Please answer these sections.

# **Risk Level of Psychological Distress**

Please answer this section.

#### **Risk Level of Psychiatric Hospitalization**

Please answer this section and the corresponding questions.

#### e Services Training Guide | Outpatient Services | 9

Was a standard instrument used to evaluate treatment progress? *	⊖Yes ⊖No
If yes, which instrument?	
	Save Submit

## **Standard Instrument and Evaluation of Treatment Progress**

Please answer this section and list any instruments used to determine if progress was made in treatment

## **Submit**

Once complete please click "Submit". Your request for authorization of outpatient services will be reviewed by a Beacon Health Options clinician. You can check on eServices after at least three business days to see if your request for authorization was approved.